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Treating Individuals Who Have Sexually Offended.

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Doctorate in Clinical Psychology

The University of Edinburgh

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Thesis Abstract

The aim of this thesis was to contribute to our understanding of the therapeutic relationship between clinicians and individuals who have committed sexual offences against children and adults. To do this a systematic review was carried out which explored the relationship between attachment styles and types of sexual offending to investigate whether there is an association between types of sexual offences and types of insecure attachment styles. 16 articles were identified and evaluated. The results of this review indicated that individuals who have sexually offended against children demonstrated more insecure childhood maternal and paternal attachments alongside higher rates of insecure adult attachment styles whereas individuals who have sexually offended against adults demonstrated a more variable pattern of maternal and paternal attachments. Types of sexual offending did appear to be related to different insecure attachment styles with child molesters predominantly identified as preoccupied and fearful and rapists classified as dismissing. A separate qualitative study using Interpretative Phenomenological Analysis was also completed which explored the experiences of therapists involved in the delivery of group treatment for sexual offenders. Some of the experiences reported were similar to those outlined in previous studies (the importance of collegial support, the experience of intrusive cognitions, managing challenging characteristics of sexual offenders and the perception of being involved in protecting the public) but some were not (the prestige felt from belonging to a niche profession, the pride of pushing professional boundaries and the perception of protecting the patient and managing professional challenges) offering further insight into the possible types of experiences encountered. An awareness and appreciation for the integral role attachment status plays in sexually deviant behaviour enables clinicians to anticipate the relational dynamics that may emerge during treatment and modify interventions appropriately to facilitate effectiveness and maintain the therapeutic alliance. In addition by exploring the experiences of sex offender therapists an understanding of the ways in which the therapeutic relationship and a therapist's sense of self may be impacted can be garnered (Hernandez, Engstom & Gangsei, 2010; Lyn & Burton, 2004) assisting individuals and organisations in ensuring that the rewards are maximised and the challenges supported and reduced.

Chapter 1. General introduction.

The development of treatment programs to reduce recidivism for individuals convicted of sexual offences has been encouraged in response to increased public knowledge and the presence of sexual offenders in the community (Gerardin & Thibaut, 2004; Patel, Lambie, & Glover, 2008). Initial treatments for sexual offenders in the 1950s and 1960s were behavioural in orientation based on the premise that sexual offences were the result of deviant sexual preferences that had evolved through conditioning (associating sexual arousal with deviant sexual fantasies) (McGuire, Carlisle & Young, 1965). Despite the prevalence of such treatments little evidence is available to support the proposition of a causal relationship between deviant sexual preferences and sexual offending (Marshall, Anderson & Fernandez, 1999; Rice, Quinsey & Harris, 1991) or that conditioning processes are implicated (O'Donohue & Plaud, 1994). Importantly there is also little evidence that behavioural treatments produce long term changes in behaviour (Quinsey, Chaplin & Carrigan, 1980). As theories pertaining to sexual offending evolved throughout the 1970s and 1980s cognitive processes were included in its etiology as contributors to offending behaviour (Marshall & Laws, 2003). As such, treatment programmes were expanded to include a number of additional components, including the skills necessary to maintain adult intimate relationships. It was proposed that the adjunct of such additional skills would facilitate the acquisition of age appropriate relationships and as such reduce deviant sexual relationships. Into the 1980s a further element was incorporated which sought to challenge distorted cognitions believed to be present in the justification and continuation of offending behaviour (Abel, Mittelman & Becker, 1985).

Currently most treatment programmes employ multi-component cognitive-behavioural therapy that is either underpinned by, or incorporates, relapse prevention frameworks (Marhsall, Anderson & Fernandez, 1999). These programmes are reflections of current theoretical conceptualizations of sexual offending incorporating physiological, psychological, social and environmental influences in the development and maintenance of offending behaviour (Finkelhor, 1984; Hall & Hirschman, 1991; Marshall & Barbaree, 1990a). These multi-component approaches are currently deemed to be the most effective treatments available however recidivism rates range from 10% to 30% within five years of release (Hanson et al., 2002; Marques et al., 2005). The, 'What Works With Sex Offenders?' publication developed by The National Offender Management Service (NOMS) (2010) reported that 'Cognitive behavioural treatment is the most effective, especially if paired with pharmacological treatment'. However a number of studies have questioned this with Ho & Ross (2012) arguing that no studies have been published, which directly compare medical and psychological treatments of sex offenders to determine the

efficacy of CBT. In addition a randomized controlled trial was carried out by Marques, Wiederanders, Day, Nelson, and Von Ommeren (2005) which assessed a prison based relapse prevention programme for sexual offenders compared to 'treatment as usual' (referring to no formal treatment) in relation to re-offending rates. The sample consisted of 259 sexual offenders in the treatment group and 445 in a control group. No significant differences were found between groups in terms of re-offending across an eight-year follow up period. Such discrepancies within the literature coupled with the high cost of these multi-component cognitive-behavioural therapy programmes indicate the need for more rigorous assessment and advancements in currently available treatments.

Across therapeutic approaches a factor recognised to be crucial in the effectiveness of interventions relates to the quality of the relationship between patient and therapist. Research has shown that the therapeutic relationship is a robust predictor of treatment outcome (Arnow, Steidtmann, Blasey, Manber, Klein, Rothbaum, Fisher, Constantino, Markowitz, Thase & Kocsis, 2013; Del Re, Flückiger, Horvath, Symonds & Wampold, 2012; Johansson & Jansson, 2010; Norcross, 2002); with poor relationships resulting in increased rates of disengagement (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Samstag, Beckham, 1992), and increased levels of hostility during sessions (Tasca & McMullen, 1992). In a meta-analysis of 79 studies by Martin, Garske and Davis (2000) a moderate effect size of .22 demonstrated that the therapeutic alliance was consistently and moderately related to beneficial changes in clients. The therapeutic relationship is said to be a product of a therapist's style and the client's perception of the therapist (Marshall, Fernandez, Serran, Mulloy, Thornton, Mann & Anderson, 2003; Walborn, 1996) with the client's perception of the therapeutic relationship deemed to be more important than a specific intervention (McLeod, 1990; Safran & Murran, 1996). Marshall, Serran, Moulden, Mulloy, Fernandez and Mann, (2002) identified that four features of the therapists' style (empathy, warmth, directiveness and rewardingness) accounted for between 30%-60% of treatment outcome variance. Additional factors include: collaboration, understanding, the perception of safety (Marshall et al., 2003) and agreement about goals (Martin et al., 2000). Drapeu (2005) and Drapeua, Koner, Brunet and Granger (2004) asked sexual offenders what they viewed to be the most helpful aspect of treatment. In line with original assertions from Rogers (1980) offenders reported that therapist skills including empathy, warmth and genuineness were pivotal. Disengaging from treatment occurred if offenders felt their therapist was unsupportive or lacking in therapeutic skills.

A number of client characteristics have been found to influence the therapeutic alliance (Clarkin & Levy, 2004; Constantino et al., 2002) with adult attachment style being one such characteristic (Bowlby, 1988; Levy, Ellison, Scott, & Bernecker, 2011; Mikulincer & Shaver, 2007). Attachment theory posits that early interpersonal relationships with caregivers form representations of relationships that give rise to attachment styles (Bowlby 1988; Fraley & Shaver, 2000). These attachment styles form a guidance system about relationships, which consist of internalized expectations (based on memories of past interactions) of an attachment figures response to oneself and leads to expectations for future relationships. When these memories are negative/inconsistent they can lead to negative cognitive biases in our expectations of others behaviours. An individual's perspective of an alliance is therefore influenced by these attachment styles and likely form a component of the alliance itself (Horvath, Del Re, Fluckiger & Symonds, 2011). Bowlby (1982) proposed that therapy may activate the attachment system with the therapist encapsulating the functions of childhood attachment figures in providing a 'secure base' from which the client can explore and a 'safe haven' when the client is distressed. Since this proposal numerous researchers have theorized as to how attachment may interact with alliance formation (Berant & Obegi, 2009; Eagle & Wolitzky, 2009; Farber & Metzger, 2009; Mallinckrodt, 2010; Mikulincer, Shaver, Cassidy, & Berant, 2009; Parish & Eagle, 2003; Safran & Muran, 2006; Holmes, 2001). Insecure attachment styles have been demonstrated to impair the development of an alliance, impeding formation where it is felt that there is an "attachment dynamic at play in alliance and in relation to outcome" (Elvins & Green, 2008). With the therapeutic alliance demonstrated to be an important predictor of outcome and attachment style shown to influence the formation of an alliance elucidating the involvement of patient attachment style has potential clinical utility (Castonguay, Constantino, & Grosse Holt- forth, 2006).

Research has highlighted that there are numerous factors involved in the development and expression of human sexuality with the perpetration of sexual offenses being no exception (Burk & Burkhart, 2003). Factors contributing to sexually deviant behaviours include genetic predispositions such as aggressiveness and impulsivity (Coccaro, Bergeman, & McClearn, 1993; New, Goodman, Mitropoulou, & Siever, 2002) and physiological variances in libido, levels of hormones and neurotransmitter functioning (Baumeister, Catanese, & Vohs, 2001; Coccaro, Kavoussi, & McNamee, 2000; Ellis, 1991; Lane & Cherek, 2000). Additional factors include the use of substances (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2001; Brecklin & Ullman, 2002; Peugh & Belenko, 2001), sociocultural expectations (Millburn, Mathes, & Conrad, 2000; Mosher & Tomkins, 1988; St. Lawrence & Joyner,

1991) and interpersonal competencies and ways of relating to others (Flewelling & Bauman, 1990; Marshall & Barbaree, 1990; Marshall & Marshall, 2000). Attachment theory has been recognised as a comprehensive etiological model of sexual offending which includes both biological and social components. This developmental model has established itself as one of the most influential contemporary conceptual frameworks for understanding the increased likelihood of sexual offending (Burk & Burkhart, 2003; Maniglio, 2012; Starzyk & Marshall, 2003) with a range of empirical studies, theoretical models and reviews implicating the disturbed parent-child attachments in later sexually deviant behaviours.

The attachment model (Bowlby, 1951, 1969, 1973, 1979, 1980) proposed that being kept warm and fed as a child is not sufficient for optimal development but that a sense of security is required, that is having ones needs attended to sufficiently in order to assuage anxiety and promote feeling understood. Early attachment provides the foundation for an infants understanding that they are understood, or held, in another person's mind. This understanding provides the mechanism by which children can start to establish their own inner emotional vocabulary and develops into the meta-cognitive ability to reflect and think about one's own thoughts and feelings as well as those of other people. Caregivers who understand the child's state of mind facilitate this learning within the child so that they are able to achieve this for themselves as they develop. This allows the individual to recognize his or her own feeling states and empathetically hypothesize about those of other people. Early attachment then also facilitates emotion regulation by instilling in the child the belief that safety is attainable if they become distressed or afraid. The expectation that other people can be trusted and turned to for support becomes an internalized belief which can be employed to self sooth and manage distressing emotions.

With a predominantly insecure attachment profile, individuals who sexually offend often present with interpersonal difficulties specifically in the maintenance of healthy intimate relationships (Hudson & Ward, 1997). The failure to develop and experience appropriate interpersonal skills and competencies in childhood may lead individuals to establish maladaptive ways of obtaining intimacy through sexual offences (McKillop, Smallbone, Wortley, & Andjic, 2012; Ward, Hudson, & Marshall, 1996). Offenders may repeatedly present with a failure to understand and control their states of mind and appear unable to comprehend the state of mind of another person (Ansbro, 2008). The research suggests that individuals in offending populations demonstrate an impaired ability to self-reflect relating to their insecure attachment styles. An individual with a dismissing attachment style then may not be able to articulate how they experienced relationships perhaps categorizing their early

family life as 'fine' despite information to the contrary. With an insecure attachment emotion regulation is also hampered, as appropriate expectations have not been internalized. When an individual feels threatened the attachment system is activated (Mikulincer & Shaver, 2007) and an individual will respond according to how they have previously learnt to regulate unpleasant feelings. With a lack of self-soothing and self-management skills individuals with an insecure attachment are more likely to reassert their emotional equilibrium through behavioural means of emotion regulation which may include sexually abusive acts, violence or substance misuse (Parsons, 2009). The attachment model is proving useful in developing current approaches to treating sexual offenders. This model would appear to be particularly beneficial for clinicians who are often required to manage difficult interpersonal issues during treatment. An awareness and appreciation for the integral role attachment status plays in sexually deviant behaviour enables clinicians to anticipate relational dynamics that may emerge throughout treatment (Lyn & Burton, 2004) and avoid damaging the therapeutic relationship.

Investigating the health of people who care for the health of others is becoming an issue of increasing interest (Cuellar-Flores, Liminana-Gras & Sanchez-Lopez, 2013) with greater levels of occupational stress and a higher frequency of minor psychiatric disturbances reported by employees in the NHS compared with other job groups in the UK (Heponiemi, Kouvonen, Sinervo & Elovainio, 2013; Wall, Bolden, Borrill, Carter, Golya, Hardy, Haynes, Rick, Shapiro & West, 1997). The task of working with people who have experienced physical or emotional harm can be challenging and some research has suggested that the challenges of this work extend to those providing treatment to perpetrators of abuse as well as victims (Ennis & Home, 2003; Moulden & Firestone, 2007). For a therapeutic relationship to develop therapists must empathetically engage with clients, which requires clinicians to identify and vicariously experience emotions (Figley, 1995). For therapists working with sexual offenders this may result in strong emotional and cognitive countertransference responses (Bengis, 1997; Kearns, 1995). Countertransference reactions can be beneficial to the therapeutic process if correctly identified and processed by the therapist providing a greater level of insight into the client and consequently an enhanced therapeutic relationship (Gelso & Hayes, 2007). If unacknowledged however, they can intrude upon a therapist's internal state, reduce a clinician's level of self-awareness and challenge their sense of identity and result in vicarious traumatisation symptoms (Gelso, Latts, Gomez & Fassinger, 2002; Ligiero & Gelso, 2002; Pearlman & Saakvitne, 1995; Rosenberger & Hayes, 2002). Despite extensive research investigating the effects of traumatic exposure on therapists who

work with victims of sexual abuse, the literature exploring the impact on those working in the forensic field is less well established (Clark & Roger, 2007).

The aim of this thesis therefore was to contribute to our understanding of the therapeutic relationship between clinicians and individuals who have committed sexual offences against children and adults. To do this a systematic review was carried out which explored the relationship between attachment styles and types of sexual offending. As a relational model, attachment theory is beneficial in contributing to our understanding of how sexual offenders may relate to and challenge the therapeutic process highlighting the patterns of cognitions and behaviours frequently reported by therapists to be challenging and potentially disruptive to the therapeutic relationship (Ansbro, 2008). A separate qualitative study was also completed which explored the experiences of therapists involved in the delivery of group treatment for sexual offenders. The systematic and widespread treatment of sexual offenders is a comparatively recent innovation in the human services field and consequently research investigating the impact of such work on care providers is still in its infancy. Research in this field may be helpful in understanding the factors involved for clinicians in maintaining a positive therapeutic relationship (Hernandez, Engstrom & Gangsei, 2010) and improving client outcomes.

Plan of thesis

Following on from this general introduction, chapter 2 presents a systematic review, which evaluates studies that have explored the attachment styles of sexual offenders with a view to considering the relationships between types of sexual offending and reported styles of attachment. The review has been written in the format required by the Journal of Aggression and Violent Behavior (Appendix I). In chapter 3 a qualitative study is presented which addresses the experiences of therapists who delivered group treatment to individuals who had sexually offended. Interpretative Phenomenological Analysis (IPA) was employed revealing reports of both positive and negative experiences. The article has been written in the format required by the Journal of Psychology, Crime and Law (Appendix II). This thesis is concluded with a discussion of additional methodological matters in Chapter 4.

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Chapter 2. Systematic Review

Attachment styles and sexual offending: A systematic review

Abstract

A range of empirical studies have proposed that disturbed parent-child attachments act as a diathesis for committing sexually deviant offences (Burk & Burkhart, 2003; Starzyk & Marshall, 2003). This review sought to identify and evaluate studies that have investigated attachment styles in sexual offenders to explore the relationship between sexual offending and attachment style, and specifically whether associations exist between attachment styles and different types of sexual offending. Five databases were searched alongside Google Scholar and hand searches of selected journals and reference sections, which revealed 1,127 citations from which 16 relevant studies were selected for this review. Authors of included articles were contacted to establish the existence of unpublished work. All papers were evaluated by the first author and 50% second coded by an independent rater. Individuals who have sexually offended against children demonstrated more insecure childhood maternal and paternal attachments alongside higher rates of insecure adult attachment styles whereas individuals who have sexually offended against adults (rapists) demonstrated a more variable pattern of paternal attachments. Types of sexual offending did appear to be related to different insecure attachment styles with child molesters predominantly identified as preoccupied and fearful and rapists classified as dismissing. Limitations are discussed alongside the implications for clinical practice in developing an understanding of individuals' offending behaviour and engagement with services.

Keywords: Sexual offender, attachment style.

1. Introduction

1.1 Attachment framework

Bowlby (1951, 1969, 1973, 1979) was the first to draw attention to the importance of the parent-child relationship in proposing the attachment behavioural system. This motivational system predisposes children to develop attachments during their first year of life to increase the likelihood of survival. The attachment system is designed to determine the proximity and availability of the primary caregiver. If the caregiver is close, accessible and attentive the child will feel loved, secure and confident enabling them to explore their environment and socialise. If the caregiver is not close, accessible and attentive the child will feel anxiety and likely exhibit a number of attachment behaviours designed to locate and engage the caregiver. Interactions with available and responsive caregivers then give rise to a sense of “felt security” (Bretherton, 1985; Sroufe & Waters, 1977) and expectations that attachment figures will be available when needed. When attachment figures are not available security is not felt and expectations as to caregiver support will likely be negative. Bowlby (1969, 1973) called these expectations, working models or mental representations of the self and other in close relationships. Working models or representations arise through interactions with significant others (Markus & Cross, 1990). Based on the responsiveness of the other, beliefs about the acceptability of the self are derived. Available, responsive and reliable others give rise to the self being represented as worthwhile and acceptable. Interactions with unavailable, unresponsive or inconsistent others alternatively gives rise to a view of the self as unacceptable and unworthy (Cassidy, 2000). These relationships then also form a person’s expectations as to how accessible significant others are and the likelihood of them responding when needed forming representations or working models of others (Main, Kaplan & Cassidy 1985).

Further work by Ainsworth, Blehar, Waters and Wall (1978) developed Bowlby’s theory to demonstrate the individual differences in how children determine caregiver accessibility and regulate their attachment behaviours. Three childhood attachment styles were identified. The first of which was a secure style in which a child expresses appropriate behaviours when separated and reunited with their primary caregiver that is upset and then pleased upon return. Anxious-resistant children become very distressed upon separation and are difficult to soothe upon the caregivers return often exhibiting contradictory behavioural signals where they want the caregiver to come close but also appear to want to push away or punish the caregiver. The third attachment style identified was avoidant where the child is not distressed upon separation and appears to avoid re-engaging with the caregiver.

Research on adult attachment was initially guided by the assumption that the same motivational system that gives rise to the close emotional bond between caregivers and children is responsible for the bond that develops between adults in emotionally intimate relationships (Hazan & Shaver, 1987). Using a three-category measure Hazan and Shaver (1987) noted that relationships between romantic adult partners are similar to those between child and caregiver with scores distributed between secure, anxious-resistant and avoidant styles. Brennan, Clark and Shaver (1998) conducted subsequent research into this area and proposed that there are two fundamental dimensions for adult attachment patterns; they are attachment related anxiety and attachment related avoidance dimensions. People high on attachment related anxiety tend to express worries about their partner's availability, responsiveness and attentiveness. People scoring low are more secure in the perceived attentiveness of their partners. People high on the attachment related avoidance dimensions tend not to rely on people or open up to others. Those low on this dimension in contrast are more comfortable being intimate and more secure. A prototypical secure adult therefore is low on both of these dimensions. Fraley and Spieker (2003a, 2003b) have subsequently identified two functionally similar dimensions for children.

Bartholomew and colleagues (Bartholomew, 1990; Bartholomew & Horowitz, 1991) developed the work by Hazan and Shaver (1987) by proposing the four-category model of attachment (Bartholomew & Horowitz, 1991) (Figure 1).

		Internal working model of self	
		Positive (Low anxiety)	Negative (High anxiety)
Internal working model of others	Positive (Low avoidance)	Secure Comfortable with intimacy and autonomy	Preoccupied Preoccupied with relationships, high emotional reactivity
	Negative (High avoidance)	Dismissing Dismissive of attachment, counter-dependent	Fearful Afraid of intimacy and rejection; believes self to be worthy of rejection; high emotional reactivity

Fig. 1 Bartholomew's four-category model of adult attachment (1991)

This model is based around the internal working models of self and other. Different combinations of positive and negative working models of self and other give rise to four attachment styles: secure (low anxiety, low avoidance); preoccupied-anxious (high anxiety, low avoidance); fearful-avoidant (high anxiety, high avoidance); dismissive-avoidant (low anxiety, high avoidance). These four attachment styles are demonstrated in relational behaviours along the two dimensions of attachment anxiety and avoidance (Figure 2). Securely attached individuals then are comfortable with intimacy and autonomy whereas preoccupied individuals require attention to alleviate their fear of rejection and abandonment. Individuals with a dismissing attachment style avoid intimacy as relationships are not valued and autonomy is preferred. Fearfully attached individuals are both anxious and avoidant regarding interpersonal interactions. While desiring attention and closeness, interactions are avoided for fear of rejection or abandonment (Bartholomew & Horowitz, 1991). The attachment style formed in childhood then appears to be highly influential for interpersonal interactions and relationships throughout an individual's life.

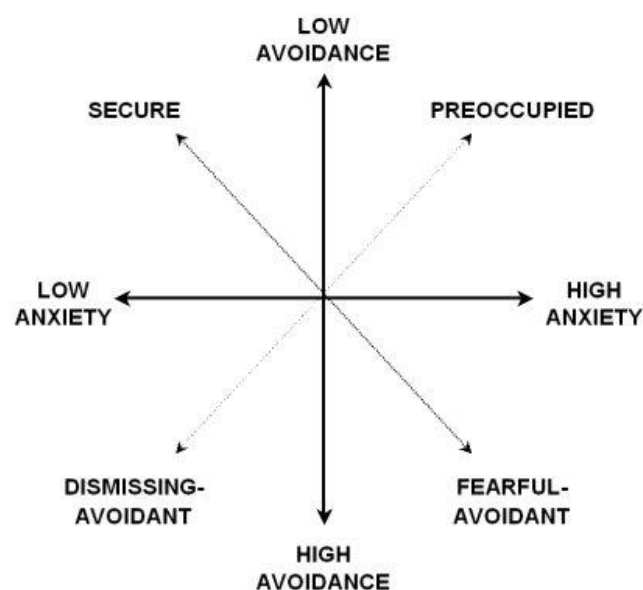


Fig. 2 Brennan et al's (1998) two-dimensional model of adult attachment interposed with Bartholomew and Horowitz's (1991) four-category model.

1.2 Attachment relationships and deviant sexual behaviour

A range of empirical studies, theoretical models and reviews have determined that disturbed parent-child attachments increase the likelihood of sexual offending (Burk & Burkhart, 2003; Starzyk & Marshall, 2003). Insecurely attached individuals may interact with others in ways that result in a reinforcement of

negative self/other internal working models leading to a reduction in social support and an increased risk of psychopathology (Greenberg, 1999; Goodwin, 2003). Current models of sexually deviant behaviours suggest that insecure parent-child attachments create vulnerabilities within a child, reducing the empathy they feel for others and instilling intimacy deficits which may set an individual along a trajectory of sexual offending (Marshall & Marshall, 2000; Craissati, McClurg, & Browne, 2002; Ward, Hudson, Marshall, & Siegert, 1995).

Disturbed attachment relationships are therefore proposed as a diathesis for committing sexually deviant offences as opposed to a direct cause for such offences (Ward & Beech, 2005). The contexts of inadequate childhood attachment relationships generally give rise to additional harmful factors such as harsh physical discipline, development of negative attitudes towards relationships (Baker, Beech & Tyson, 2006; Ward, Hudson, Marshall, & Siegert, 1995) poor self regulatory skills, negative self perceptions, low self esteem and so on. Adolescents who have experienced these types of negative caregiver experiences report poor social skills throughout adolescence with limited ability to meet intimacy needs (Marshall & Barbaree, 1990). During the pubescent period reduced confidence in establishing relationships might be coupled with high levels of masturbation to fantasies of power and control which over time may become more deviant in nature (Marshall & Marshall, 2000). When coupled with low social competence and disinhibiting factors such as alcohol, individuals may attempt to establish an intimate relationship with non-consenting adults or children (Marshall & Marshall, 2000).

1.3 Clinical implications

The attachment model has implications for both the assessment and the treatment of sexual offenders. It is important to identify attachment styles and associated beliefs and interpersonal strategies as different types of attachment styles may require modifications to therapeutic approaches. Individuals with an anxious/ambivalent attachment style for example may require a greater degree of support and more gentle approaches to challenging in order to accommodate their negative self-perceptions and tendency to overvalue others (Ward, 1995). The attachment model may also be of benefit regarding relationship issues specifically for social skill interventions and intimacy deficits. For some individuals somewhat effective social skills may mask difficulties in establishing and maintaining warm and satisfying intimate relationships. Using cognitive interventions to assist in identifying and challenging core beliefs and attitudes related to attachment style may therefore be fruitful.

In line with social-cognitive research, a focus on the affective aspects of relationships can also be informed by an understanding of childhood and adult attachment patterns. A primary function of the internal working models is to regulate emotion (Kobak & Sceery, 1988). Working models are proposed to contain detailed information pertaining to interpersonal experiences (what occurred, where, when, who was present) alongside how the individual felt (anger, joy, fear) (Bretherton, 1985). These detailed stores of information influence what individuals attend to, how they interpret their world and what additional information is encoded and remembered. As working models, or representations, this influence is exerted outside of conscious awareness (Bowlby, 1980; Bretherton, 1985, 1990; Main et al, 1985). With past attachment experiences encoded in memory current relationships can reactivate those memories along with associated affect. By exploring these past relationships and developing an understanding of attachment styles the type of strategy a person selects to cope with situations may be addressed. By using an attachment framework, and holding the offenders' possible self/other working models in mind, therapists can mindfully assist in disconfirming maladaptive beliefs and self-defeating behaviours (Safran & Segal, 1991).

2. Aims of the review

The primary aim of this review was to explore the relationship between sexually deviant behaviours and attachment style. A secondary aim of this review examined whether different types of sexual offending are distinguishable from one another in relation to attachment style.

3. Inclusion and exclusion criteria

3.1. Population

The studies included in this review were restricted to those exclusively using adults (over the age of 18 years) who had been charged with committing a sexual offence. A high percentage of identified sexual offenders are male and as such this review excluded female offenders. A separate literature exists concerning juvenile offenders so studies of this nature were also excluded. Sexual offences included those that were targeted towards children and those targeted towards peers/adults. Studies were included that took their samples from prison populations, community based outreach programmes and forensic inpatients populations. All nationalities were included. Unless being used as a comparison group, participants whose primary reason for detainment related to a violent or non-violent crime were excluded.

3.2. Intervention

Studies were included which explored the attachment styles of individuals who had committed sexually deviant offences.

3.3. Outcome measures

Studies were required to have used a valid and reliable measure of childhood and/or adult attachment styles. Assessment measures included, but were not restricted to, interview based measures such as the Adult Attachment Interview (Kaplan & Main, 1985) and questionnaire and rating scale based measures such as the Relationship Questionnaire (Bartholomew & Horowitz, 1991). Appendix III includes details of all the measures used by selected studies.

3.4. Study design

Case control studies and one cohort study were included in the review. Single case studies and qualitative studies were excluded. Although case studies and qualitative studies provide valuable information they can be limited in their ability to establish valid inferences about the relationships between variables and are therefore limited in their generalisability.

4. Literature search strategy

Literature searches were conducted between November and December 2013 and involved searching selected databases, hand searching selected journals and search engines, manual reference list searches and contacting authors for unpublished pieces of work. The Cochrane library was searched to ascertain whether a similar systematic review had been published which was not found to be the case.

Databases were searched on the 22nd of November, the 12th of December 2013 and again on the 10th of April 2014. Searches included the earliest articles published by each database to the search date. The search descriptors used varied between databases according to the thesaurus function and therefore differed between databases. The following search strategies were used.

PsychINFO (1987-April 2014; "Attachment Disorders" OR "Attachment Behavior" OR "Attachment Theory" AND "Sex Offenses" OR "Sexual Abuse" OR "Paraphilias" OR "Incest" OR DE "Pedophilia"), CINAHL (1937-December 2013; "Attachment Behavior" OR "Risk for Altered Parent-Infant-Child Attachment" OR

"Parent-Infant Attachment" OR "Attachment styles" AND "sex offences" OR "Sex Offenders" OR "Child Abuse, Sexual" OR "Repeat Offenders" OR "sexual offender" OR "Disorders of Sex Development" OR "Sexual Dysfunction"), MEDLINE (1966-April 2014; "Attachment theory" OR "Attachment styles" OR "Mother-Child Relations" OR "Parent-Child Relations" AND "Sexual offender" OR "Rape" OR "Sex Offenses" OR "Perpetrators of sexual assault" OR "Pedophilia"), EMBASE (1980-April 2014; "Attachment" OR "Mother-Child Relations" OR "Parent-Child Relations" AND "Sexual offender" OR "Rape" OR "Sex Offenses" OR "Perpetrators of sexual assault" OR "Pedophilia" OR "Adult Rape" OR "Sex Offenses"), Psychology and Behavioural Sciences Collection (1994- April 2014; "Attachment Styles" OR "Attachment Theory" AND "Sexual Offenders" OR "Sexual Offences" OR "Sexual Deviancy").

From these searches 1,127 articles were obtained. 163 were identified as duplicates and removed this left 964 articles. Of these remaining articles, 871 were removed after screening the title. To be retained titles needed to include references to attachment styles and sexual offending. The abstracts of the remaining 93 articles were screened and 74 excluded leaving 19 articles to be included in the systematic review (see Fig. 3). Articles were excluded for a variety of reasons including: adolescent or female sample, not relevant to topic and single case or qualitative design (See Appendix IV for full details). In addition seven journals and a Google Scholar based search was conducted revealing an additional paper raising the number of articles to be included to 20. The reference sections of the selected articles were also searched revealing one additional paper raising the number of articles to be included to 21 (see Figure. 3).

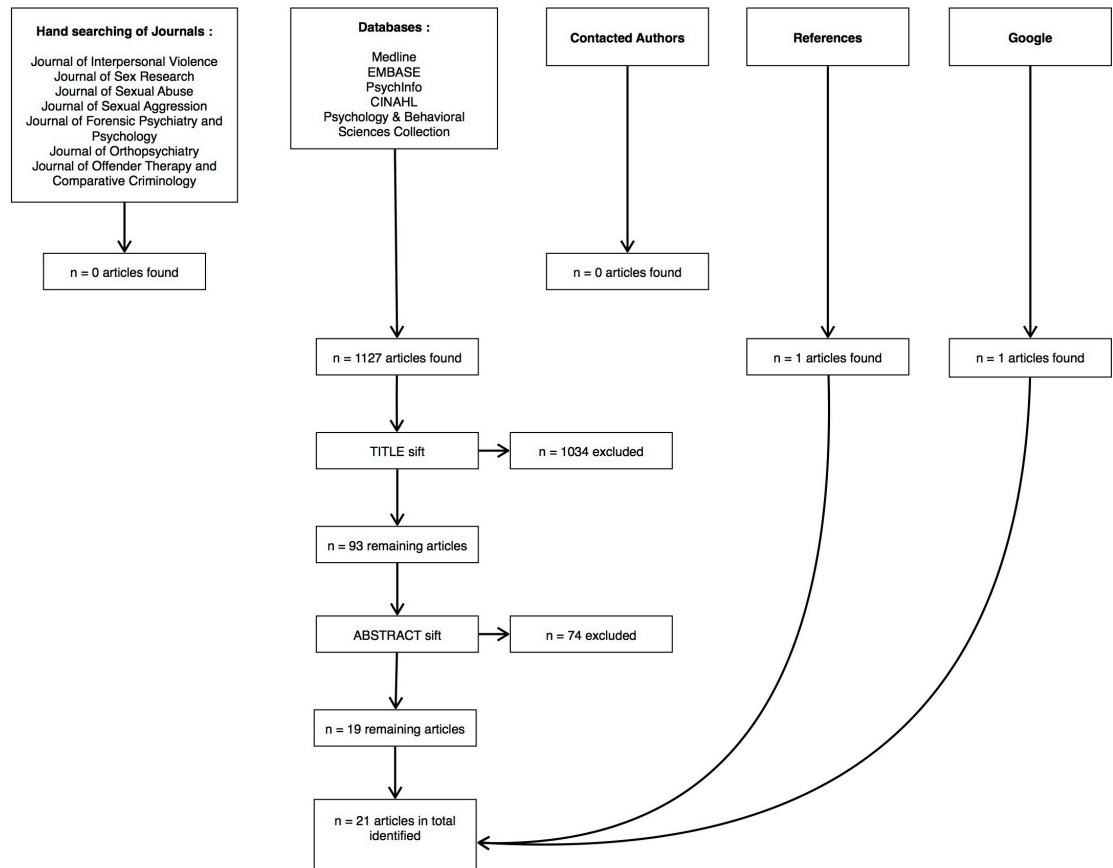


Fig. 3. Flow chart illustrating the search process

First, where possible, authors of the 21 articles to be included in the systematic review were contacted by email to determine their awareness of any unpublished but potentially relevant studies to include in the review. The authors who responded were not aware of any additional unpublished works. Figure 4 provides details on the search process for each of the five databases. Three articles were excluded at the quality stage, Lu and Lung (2012), Lyn and Burton (2005) and Hudson and Ward (1997). Upon closer inspection attachment was found not to be the primary outcome measure for Lu and Lung (2012), Lyn and Burton (2005) used the same sample as their 2004 paper and Hudson and Ward (1997) used attachment style as a categorising variable as opposed to offender type. The remainder of this review therefore relates to the results of 18 articles.

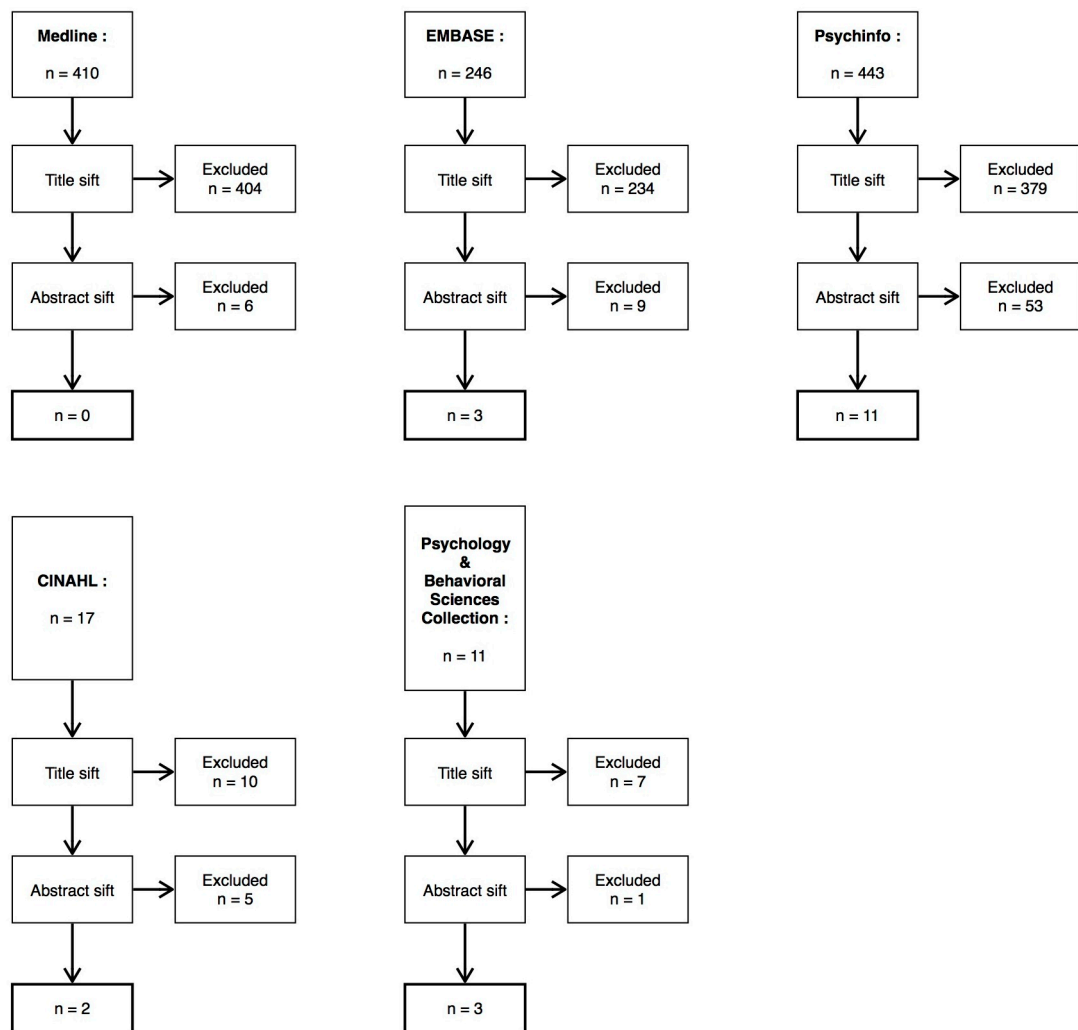


Fig. 4. Flow charts of search process within each database.

5. Quality assessment of included studies

A number of evidence-based guidelines have been established to guide the critical appraisal of research for systematic reviews in healthcare settings. Guidance from The Scottish Intercollegiate Guidelines Network (SIGN), the Critical Appraisal Skills Programme (CASP), The National Institute for Health and Care Excellence (NICE) and the Centre for Research and Dissertations (CRD) was followed in order to establish a quality appraisal tool with which to rate the quality of the 18 articles included in this systematic review. These documents were consulted to ensure that the appropriate and necessary criteria for case control and cohort articles were included in the assessment tool alongside criteria specifically related to this topic. A total of 12 quality criteria were developed to assess the 18 articles selected. Each criterion was scored as either: *Well covered* = 3, *adequately addressed* = 2, *Poorly*

addressed = 1, or *not addressed/not reported/not applicable* = 0 (see Appendix V for full details of the criteria). A total score was then calculated for each paper and converted into a percentage. Scores above 70% were classed as of 'good' quality, above 50% as of 'fair' quality and those less than 50% of 'poor' quality. A second rater was included in this process and independently coded 50% of the articles to ensure inter-rated reliability. A Kappa co-efficient for overall agreement of 0.78 was obtained indicating adequate inter-rater reliability (Randolph, 2008). All discrepancies in rating scores were discussed and resolved to both parties satisfaction. Those articles rated as of 'good' and 'fair' quality were included in the analysis. A total of 16 articles were therefore reviewed.

6. Results

6.1. Characteristics of included studies

A summary of the 16 identified articles is presented in Table 1 followed by a narrative synthesis of the findings below. See Appendix IV for a table of studies excluded at the abstract sift stage accompanied by reasons for exclusion. Fifteen of the studies were case controlled studies (Bogaerts & Vanheule 2005; Craissati, McGlurg & Browne, 2002; Jamieson & Marshall, 2000; Lyn & Burton, 2004; Marsa, O'Reilly, Carr, Murphy, O'Sullivan, Cotter & Hevey, 2004; Marshall, Serran & Cortoni, 2000; McKillop, Smallbone, Wortley & Andjic, 2012; Sawle & Kear-Cowell, 2001; Schneck, Bowers & Turkson, 2012; Simons, Wurtele & Durham, 2008; Smallbone & Dadds, 1998; Stirpe, Abracen, Stermac & Wilson, 2006; Ward & Marshall, 1996; Wood & Riggs, 2008 and Wood & Riggs, 2009) and one was a cohort study (Baker and Beech, 2004).

Table 1. Summary of identified articles

Author & Country	Aim of study	Participants	Sample population and setting	Outcome measures	Main findings	Database
Baker & Beech (2004), UK	Investigate the presence of various constructs in sexual and violent offenders.	56	20 sex offenders (against women), 15 sex offenders (against men) recruited from two prisons. 21 community controls recruited from local employers of manual workers, psychiatric hospital, university estates department and employment agency.	Relationship Scales Questionnaire (RSQ), Young Schema Questionnaire (YSQ), Dissociative Experiences Scale II (DES-II), Paulhua Deception Scales (PDS) and an Interpersonal behaviour checklist.	The Relationship Styles Questionnaire was used as a dimensional measure and indicated no significant differences between sexual offenders, violent offenders and community controls for the anxiety or avoidance attachment subscales.	CINAHL
Bogaerts et al. (2005), Belgium	To clarify the relations between recalled parental bonding in childhood, current adult attachment style and personality disorders in child molesters.	164	84 child molesters recruited from an educational training facility and from a prison in Belgium. 80 matched controls selected from Louvain in Belgium.	The parental Bonding Instrument (PBI), The Adult Attachment Scale (AAS) and the DSM-IV personality disorder criteria.	When compared to their non-offending control group the group of child molesters were characterised by insecure attachment patterns with significantly fewer child molesters reporting secure attachment styles. High scores of paternal autonomy and low maternal care increased the likelihood of becoming classified as a child molester	PsychINFO
Craissati et al. (2002)	Explore the parental bonding experiences of two groups of sexual offenders.	76	57 child molesters and 19 rapists from a community based assessment and treatment program for sex offenders.	Parental Bonding Instrument (PBI).	Child molesters reported a higher frequency of affectionless-control parental styles compared to rapists and general population data. Rapists were not found to differ from the general population data in terms of anxious/avoidant attachment styles.	EMBASE

Jamieson & Marshall (2000), Canada	To test the implications of the theory that sexual offenders present with intimacy deficits and insecure attachments.	81	20 familial offenders, 20 nonfamilial child molesters and 20 nonsexual offenders were recruited from two Canadian federal penitentiaries. 21 community controls.	The Marlowe-Crowne social desirability scale and The Relationship Questionnaire (RQ).	Reports of a fearful avoidant adult attachment style was five times more likely than a secure style in the nonfamilial child molester group compared with the community and nonsexual offender groups. Familial offenders did not differ in reported attachment styles compared to the community and nonsexual offender groups.	PsychINFO
Lyn & Burton (2004), USA	Explore whether insecure attachment distinguishes sexual from nonsexual offenders.	178	144 sexual offenders (11 rapists, 103 both child and adult offenders) and 34 nonsexual offenders recruited from a low security prison.	Self Report Delinquency Scale (SRDS), Experiences in Close Relationships Inventory (ECRI), Carlson Psychological Survey (CPS).	Sexual offenders were distinguishable from nonsexual offenders in security of attachment. Attachment style partially distinguished between types of sexual offender with child molesters significantly more likely to be insecurely attached. Attachment was not related to the characteristics of the individual's offence with the exception of victim age.	PsychINFO
Marsa et al. (2004), Ireland	Assessed adult attachment, current emotional loneliness, locus of control and anger management in offender and control samples.	119	29 child sex offenders (16 intrafamilial, 13 nonfamilial) from a voluntary prison based sexual offending treatment programme. 30 violent offenders (from 4 Irish prisons), 30 nonviolent offenders (from 4 Irish prisons), 30 community controls from a vocational training center in Dublin, university research participants' panel and a wholesale company.	Experiences in close relationships inventory (ECRI), Parental bonding instrument (PBI), The University of California Los Angeles (UCLA) emotional loneliness scale (EL), The Nowicki-Strickland locus of control scale (LOC), Novaco anger scale (NAS) and the Personal reaction inventory.	Significantly lower levels of maternal and paternal care and higher rates of maternal and paternal overprotection during childhood reported by the sex offender group compared with comparison groups. 7% of sex offenders had a secure attachment style. A secure attachment was four times less likely in the sex offender group than the other three groups. Sexual offenders were significantly more likely to demonstrate fearful attachment styles.	CINAHL

Marshall et al. (2000), Canada	To determine the relationship among intimacy deficits, loneliness and poor attachment styles in child molesters.	83	30 nonfamilial child molesters, 24 nonsexual offenders were recruited from a maximum or medium security Canadian penitentiary. 29 community nonoffenders were recruited through a local government employment agency.	The Childhood Attachment Questionnaire (CAQ), The Coping Inventory for Stressful Situations, The Sexual Abuse Questionnaire and The Marlowe-Crowne social desirability scale.	Sexual offenders were not distinguishable from comparison groups with all subjects reporting more secure maternal attachments compared with paternal attachments.	PsychINFO
McKillop et al. (2012), Australia	To test the role of attachment problems in the onset of sexual offending.	107	107 child sexual offenders (50 familial, 49 nonfamilial) recruited from Brisbane, Australia.	The Childhood Attachment Questionnaire (CAQ), The Parental Bonding Instrument (PBI), The Experiences in Close Relationships Inventory (ECRI and ECRI-State) and The Marlowe-Crowne social desirability scale.	Offenders were more likely to report insecure childhood paternal attachment relationships than those with their mothers. The sexual offenders were more likely to report insecure adult attachments. Familial and nonfamilial offenders did not differ in their patterns of maternal and paternal attachment insecurity or adult attachment.	EMBASE
Sawle & Kear-Cowell (2001), Australia	Investigate the relationship between pedophilia, insecure attachment and sexual abuse.	70	25 child sexual offenders from custodial and community based treatment programs. 22 victims of sexual abuse were recruited from two community based treatment programs. 23 university students recruited from a distance education university program.	The Attachment Style Questionnaire (ASQ) and the Child Abuse and Trauma Scale (CAT)	Individuals in the control and victim groups were significantly more securely attached than the pedophile group.	PsychINFO
Schneck et al. (2012)	Investigate the sex role orientation and attachment styles of sexual offenders.	50	25 sexual offenders (local treatment center), 25 community controls (local community college).	Experiences in Close Relationships-Revised.	Sexual offenders demonstrated significantly more anxious but not avoidant styles compared with community controls.	Google Scholar search

Simons et al. (2008)	To identify the distinct developmental experiences associated with child abuse and rape.	269	137 child molesters, 138 rapists from medium and minimum security prisons.	Childhood Attachment Questionnaire (CAQ)	Significantly more anxious attachment bonds in the child molester group compared with rapists. Rapist group demonstrated higher avoidant attachment scores and significantly weaker paternal compared to maternal relationships.	EMBASE
Smallbone & Dadds (1998), Australia	Explore childhood experiences of individuals who continue on to sexually offend.	80	16 incarcerated adult rapists, 16 intrafamilial child molesters, 16 extrafamilial child molesters, 16 incarcerated property offenders, 16 male correctional officers. All recruited from 3 correctional centers in South East Queensland, Australia.	The Childhood Attachment Questionnaire (CAQ), The Relationship Scales Questionnaire (RSQ) and an attachment history checklist.	Sexual offenders demonstrated significantly less secure maternal, paternal and adult attachments than correctional officers. Sexual offenders reported significantly less secure childhood maternal attachments than property offenders. No differences between intrafamilial sexual offenders and the other three groups for maternal anxious, paternal anxious or adult anxious attachment styles. No significant differences between rapists and the other groups for maternal avoidant, paternal avoidant or adult attachment.	PsychINFO
Stirpe et al. (2006), Canada	Investigate the state-of-mind regarding childhood attachment among groups of sexual offenders.	101	22 extrafamilial child molesters, 19 intrafamilial child molesters, 20 adult sex offenders, 20 violent nonsexual offenders and 20 non-violent offenders. from the federal or provincial correctional systems in the Ontario region of Canada.	Adult Attachment Interview (AAI).	The majority of sexual offenders were categorised as insecure in contrast to normative sample data. Child molesters were significantly more likely to be preoccupied whereas rapists and violent offenders and to a lesser extent familial offenders were dismissing. Nonviolent offenders were comparatively more secure.	PsychINFO

Ward & Marshall (1996), New Zealand	Preliminary investigation into the nature of attachment relationships in sex offenders.	147	55 sexual offenders (against children), 30 sexual offenders (against adult women), 32 violent offenders, 30 nonviolent nonsexual offenders. Recruited from two medium security prisons in New Zealand.	The Relationship Questionnaire (RQ) and The Relationship Scales Questionnaire (RSQ).	Sexual offenders reported more insecure adult attachment styles. Child molesters reported more fearful or preoccupied attachment styles than rapists' who exhibited more dismissing attachment styles. Violent offenders characterised by more dismissing attachment styles and nonviolent nonsexual offenders were the most securely attached.	Psychological and Behavioural Sciences Collection
Wood & Riggs (2008), USA	To examine the contribution of adult attachment style, cognitive distortions and empathy to the prediction of child molester status.	112	61 child molesters were recruited through community treatment providers, 51 controls were recruited through local businesses, neighborhoods and churches.	The Experiences in Close Relationships Scale (ECR), the Child Molester Scale (CMS) and The Marlowe-Crowne social desirability scale.	Attachment anxiety was a significant predictor of child molester categorisation. Attachment avoidance was not found to be a predictor of child molester status. Individuals with high levels of attachment anxiety are likely to exhibit a preoccupied style of attachment.	PsychINFO
Wood & Riggs (2009), USA	To examine child molester status and romantic attachment style in relation to cognitive processes and distortions about adult-child sex.	188	96 child molesters were recruited through community treatment providers, 92 controls were recruited through local businesses, neighborhoods and churches.	The Marlowe-Crowne social desirability scale, The experiences in close relationships scale (ECR), The cognitive triad inventory (CTI), The child molester scale (CMS).	Child molesters were more likely to exhibit fearful or preoccupied attachment styles when compared to nonoffending participants who were more likely to be classified as secure. Sexual offenders were distinguishable from nonoffenders with regard to their attachment style profile.	PsychINFO

6.2. Summary of results – attachment styles and sexual offending behaviour

6.2.1. Case controlled studies

Bogaerts et al. (2005) described the outcome of two separate studies investigating recalled parental bonding, adult attachment style and personality disorders in child molesters using The Parental Bonding Instrument (PBI) and The Adult Attachment scale (AAS). When compared to their non-offending matched control group the child molester sample were characterised by less secure adult attachment patterns with significantly fewer child molesters reporting secure attachment styles. The child molester group reported significantly reduced maternal and paternal care and high paternal autonomy indicating a 'neglectful' prominent parenting style. Their logistical regression model indicated that high scores on paternal autonomy, antisocial personality disorder and schizoid personality disorder were found to be strong predictors of being classified as a child molester. High scores for maternal care however were found to act preventatively reducing the likelihood of being classified as a child molester.

Craissati et al. (2002) investigated the parental bonding experiences of individuals who had offended sexually against children and adults using the Parental Bonding Instrument (PBI). The child molester and rapist sample did not demonstrate statistically different results across maternal and paternal scales. Child molesters however were significantly more likely to rate their parents' prominent parenting style as 'affectionless control' (i.e. low care high with over-protection/control) compared to rapists and the general population. The rapists' scores did not differ significantly from the general population.

Jamieson and Marshall (2000) used The Relationship Questionnaire (RQ) to explore attachment styles in familial and nonfamilial child molesters compared with nonsexual offenders and a community sample of nonoffenders. 70% of the nonfamilial group reported insecure attachments (50% fearful and 20% dismissive), 55% of the familial group reported insecure attachments (10% preoccupied, 20% fearful and 25% dismissive). Nonfamilial child molesters rated themselves significantly higher for fearful avoidant attachment styles than the community and familial samples. Familial offenders did not differ in reported attachment styles compared to the community and nonsexual offender groups. The attachment styles of familial offenders more closely resembled those of the community group with the nonfamilial offenders reports closer to those of the nonsexual offender sample offering partial support for the hypothesis that sexual offenders differ in their

attachment styles compared to nonoffenders and that attachment styles differ between types of sexual offending.

Lyn and Burton (2004), included sexual offender and nonsexual offender groups to determine whether insecure attachment styles differentiated the two offending groups using the Experiences in Close Relationships (ECR) measure. Attachment style was calculable for 89% of the sexual offending group and 75% of the nonsexual offender group. Rates of insecure attachment were high for both groups. 85% of sexual offenders were insecurely attached compared to 64% of the nonsexual offending group. 56% of the sexual offending group were characterised as fearfully attached, 17% preoccupied and 11% dismissing. This was compared to the nonsexual offending group of which, 20% were reported to be in the fearful category, 20% preoccupied and 24% dismissing. Their results indicated a significant association between insecure attachment and sexual offending with insecurely attached subjects five times more likely to be from the sexual offender group. Specifically being categorised as fearfully attached was significantly associated with having a history of sexual offending. Preoccupied and dismissing categories were not significantly associated with sexual offender status. To explore whether attachment styles differed between types of sexual offending a series of chi-square analyses were conducted. For this analysis the sexual offender group was subdivided in to those who reported committing a sexual offence against an adult (n=11) and individuals who had offended against both adults and children (n=103). There was a significant association between victim age and attachment status. 87% of offenders who had committed child only sexual offences were insecurely attached compared with 63% of adult and child sexual offenders. Lyn and Burton (2004) therefore concluded that insecure attachment significantly differentiated between sexual and nonsexual offenders and that attachment styles partially distinguished between types of sexual offenders with men who offend against children significantly more likely to be insecurely attached than those who offend against adults.

Marsa et al. (2004) included samples of child sexual offenders, violent offenders, nonviolent offenders and community controls to examine the relationship between attachment styles and child sexual offenders in Ireland. Using the Experiences in Close Relationships Inventory (ECRI) the child sex offender group reported significantly lower rates of maternal care and significantly higher rates of maternal and paternal overprotection indicating a prominent parenting style of 'affectionless control'. Only 7% of the child sexual offenders were rated as securely attached compared to 30%-45% of the violent offenders, nonviolent offenders and

community controls. These other groups were found to be four times more likely to be securely attached. The child offender group was significantly more likely to demonstrate a fearful adult attachment style (59%), which was eight times more than were characterised as secure. Rates of preoccupied adult attachment style did not differ between groups. Child offenders also demonstrated significantly greater levels of interpersonal anxiety and avoidance on the two dimensional scales of the ECRI when compared with the nonviolent offenders and the community control group.

Marshall et al. (2000) investigated the childhood attachments, coping styles and sexual abuse histories among a group of nonfamilial sexual offenders, nonsexual offenders and nonoffenders. Results on The Childhood Attachment Questionnaire (CAQ) did not differentiate between groups with results demonstrating reports of greater maternal attachments than paternal attachments across all three groups. The dominant maternal attachment style reported was secure with paternal attachment styles evenly distributed across secure, anxious/ambivalent and avoidant.

McKillop et al. (2012) utilised self-report data collected from 107 male child sexual offenders (55 familial and 49 nonfamilial child molesters) to explore the role of attachment problems in the onset of sexual offending. The Childhood Attachment Questionnaire (CAQ) was used alongside the Parental Bonding Instrument (PBI), the Experiences in Close Relationships Inventory (ECRI) and a modified version of ECRI, which enabled assessment of state adult attachment (ECRI-State). 51% of the sample reported an insecure childhood maternal attachment style with 63% reporting an insecure childhood paternal attachment. Paternal attachments were significantly less secure than maternal attachments. Familial and nonfamilial child molesters did not report significantly different results. The prominent parenting style of both mothers (45%) and fathers (50%) was 'affectionless control' (low care and high control and overprotection). 21% and 14% of maternal and parental relationships were characterised as optimal. 76% of the offenders reported an insecure adult attachment style, non-familial (80%) and familial (73%) onset offenders were not distinguishable in terms of the prevalence of insecure attachments. 43% were categorised as fearful-avoidant, 25% as preoccupied anxious and 9% dismissive-avoidant. The sexual offenders in this study were more likely to report insecure rather than secure attachment styles and insecure general (trait) adult attachments. Offenders were more likely to report insecure childhood paternal attachment relationships than those with their mothers. Additionally continuity from childhood attachment style to adult attachment style was discernable but weaker than expected with insecure childhood attachment more stable than secure childhood attachment. Offenders'

adult attachment was also reported to become more insecure in the period preceding the onset of a sexual offence.

Sawle and Kear-Cowell (2001), investigated adult attachment styles across a group of male child molesters, male sexual abuse victims and a control group using the Attachment Styles Questionnaire (ASQ). Individuals in the control and victim groups were significantly more securely attached than the child molester group demonstrating higher scores for the Confidence scale. The child molester group was significantly more insecurely attached than the control and victim group scoring higher on the Relationship as Secondary scale. The control and victim groups were not significantly different on the Confidence or Relationships as Secondary scales. When the four insecure attachment styles scores were pooled the three groups differed. The child molester and victim group were significantly more insecure than the control group. However the victims' pattern of results indicated that they were more similar to the controls in their Confidence and Relationships as Secondary scores indicating that while they have issues with insecure attachments, they are securely attached unlike the child molester group.

Schneck et al. (2012) used The Experience in Close Relationships – Revised measure in their study exploring the sex role orientations and attachment styles of sexual offenders. Details as to the types of sexual offences perpetrated were not provided. Their results however showed that the sexual offender group was significantly different from the community control group for anxious/ambivalent attachment styles. The sexual offender group demonstrated a higher frequency of anxious attachments but did not differ for scores on the avoidance scale.

Simons et al. (2008) used a modified version of the Childhood Attachment Questionnaire (CAQ) to investigate the parental attachment bonds in 132 child molesters and 137 rapists. The child molester sample reported more anxious attachment (62%) relationships compared to rapists (20%). Within the child molester sample there were no significant differences between maternal and paternal attachment scores. Within the rapist sample however higher avoidant attachment bonds were evident (76%) compared to child molesters (27%) and paternal attachment relationships were significantly weaker than maternal attachment bonds.

Smallbone and Dadds (1998), described the childhood and adult attachment styles of incarcerated sexual offenders using The Childhood Attachment Questionnaire (CAQ) and The Relationship Scales Questionnaire (RSQ). Adult rapists, intrafamilial child molesters and extrafamilial child molesters were included in the analysis alongside two comparison control groups of incarcerated property

offenders and male correctional officers. The sexual offenders (combined rapist, intrafamilial and extrafamilial child molester groups) demonstrated significantly less secure childhood maternal and paternal attachments than correctional officers. Sexual offenders also exhibited significantly less secure adult attachments than the correctional officers. Compared to property offenders, sexual offenders reported significantly less secure childhood maternal attachments. No differences were apparent between these two groups for childhood paternal attachments or adult attachment patterns. No differences were apparent between the intrafamilial sexual offender group and the other three groups for maternal anxious, paternal anxious or adult anxious attachment styles. Adult rapists were also not found to significantly demonstrate a more avoidant attachment style compared to the other groups. It was possible to differentiate sexual offenders from nonoffenders, with sexual offenders reporting less secure childhood and adult attachments. Partial support was found for distinguishing sexual offenders from nonsexual offenders with sexual offenders less secure in childhood maternal attachment. No differences in attachment styles between types of sexual offenders were apparent for global measures of anxious or avoidant adult attachment.

Stirpe et al. (2006) used a normative data set to compare the states-of-mind regarding attachment styles using the Adult Attachment Interview (AAI). Three groups of sexual offenders (nonfamilial child molesters, familial offenders and rapists) were included accompanied by a group of violent offenders and a group of nonviolent offenders. Secure classifications were greatly reduced for nonfamilial and familial child molesters, and rapists (9%, 10% and 10% respectively) compared with the general population (45-55%). Familial offenders and rapists demonstrated a higher percentage of dismissing classifications (42% and 45% respectively) than the general population (20-35%). Familial offenders and rapists also had a higher percentage of Unresolved State of Mind classifications (26% and 20% respectively) than the general population (15-20%). When all five-classification categories were investigated the percentage of preoccupied classifications was higher for the sexual offender group (21%) than the general population (10-15%). Familial offenders (15%) were comparable to the general population, with rapists (5%) reporting reduced rates of preoccupied attachments. The Cannot Classify category was high for sex offenders as a group. No differences were found between sexual offender group and the nonviolent and violent groups. When only the dismissing, secure and preoccupied categories were investigated 13% of sexual offenders were classified as securely attached, 52% were classified as dismissing and 43% preoccupied compared with the general population (57-62%, 22-28% and 15-18% respectively). The nonfamilial child molester group was more likely than the other groups to have a preoccupied state of

mind. Violent offenders, rapists and familial offenders were more likely to have dismissing attachment styles and nonviolent offenders were more likely to have secure attachments styles. Sexual offenders then were found to report more insecure attachments and differences in attachment styles between types of sexual offenders were apparent.

In their 1996 study Ward and Marshall investigated attachment relationships in men who have sexually offended against children, men who had sexually offended against adults, violent offenders and nonsexual/nonviolent offenders. Both the Relationship Questionnaire (RQ) and The Relationship Scales Questionnaire (RSQ) were used to enable discrimination between different types of insecure attachments. Sexual offenders were found to report more insecure adult attachment styles. 78-82% of child molesters and 69% of rapists were insecurely attached with child molesters reporting more fearful or preoccupied attachment styles than rapists' who tended to be similar to violent offenders on the avoidant-dismissing subscale and exhibited more dismissing attachment styles. The insecure nature of the sexual offenders attachment styles then was not found to be a unique feature of this group but was also apparent in the violent offender group. Types of sexual offenders were differentiable from one another however with child molesters being more fearful or preoccupied and rapists being more dismissing in their attachment styles.

Wood and Riggs (2008) used The Experiences in Close Relationships Scale (ECRS) to explore adult attachment, cognitive distortions and empathy in a group of paroled child molesters and a community control sample. Using logistic regression models Wood and Riggs (2008) demonstrated that attachment anxiety was a significant predictor of child molester categorisation. Attachment anxiety increased child molester status by 56% with each unit increment. Attachment avoidance was not found to be a predictor of child molester status. In their 2009 study, Wood and Riggs reported that child molesters were more likely to exhibit fearful or preoccupied attachment styles when compared to nonoffending participants who were more likely to be classified as secure. In the child molester group 47% were classified as secure, 18% fearful, 20% preoccupied and 16% dismissing. In the nonoffending group 73% were classified as secure, 8% fearful, 3% preoccupied and 16% dismissing. In both studies sexual offenders were distinguishable from nonoffenders with regard to their attachment style profile.

6.2.2. Cohort design study

Baker and Beech (2004) investigated dissociative experiences and variability over time with regard to attachment dimensions, early maladaptive schemas and interpersonal behaviour. The Relationship Styles Questionnaire (RSQ) was used as a dimensional measure and indicated no significant differences between sexual offenders, violent offenders or the community controls for the anxiety or avoidance attachment subscales.

6.3. Summary across all studies

The majority of studies included in this review identified a relationship between an insecure childhood and adult attachment style and sexual offending when compared with controls. It would appear that individuals who have sexually offended against children report more anxious childhood maternal and paternal attachments alongside higher rates of insecure adult attachment styles. Specifically parental styles of child molesters were primarily categorised as 'affectionless control' (low care and high protection). Individuals who have sexually offended against adults demonstrated a more avoidant pattern of paternal attachments but this was variable and not consistently indicated across studies. Types of sexual offending appeared to be related to different insecure attachment styles with child molesters predominantly identified as preoccupied or fearful and rapists and familial child molesters classified as dismissing. The inclusion of different offending samples and attachment measures however increased the difficulty in unequivocally determining whether it is possible to distinguish between different types of sexual offenders based on attachment styles (see Figure 5).

6.4. Quality of included studies

Table 2 depicts the values obtained by the identified papers for each of the 12 quality criteria (See Appendix V for full details relating to criteria). The rating scale acts as a guide to determining the methodological strengths and limitations of each of the articles. The appraisals indicated that Marsa et al. (2004) and Smallbone and Dadds (1998) presented the most methodological robust studies. Of the remaining fourteen, five were rated as of 'Good' (70%+) quality (Lyn et al., 2004; Marshall et al., 2000; Stirpe et al., 2006, Wood & Riggs, 2008; Wood & Riggs, 2009) and nine as of 'fair' (60%+) quality (Baker & Beech, 2004; Bogearts et al., 2005; Craissati et al., 2002; Jamieson & Marshall, 2000; McKillop et al., 2012; Sawle et al., 2001, Schneck et al., 2012, Simons et al., 2008; Ward & Marshall, 1996).

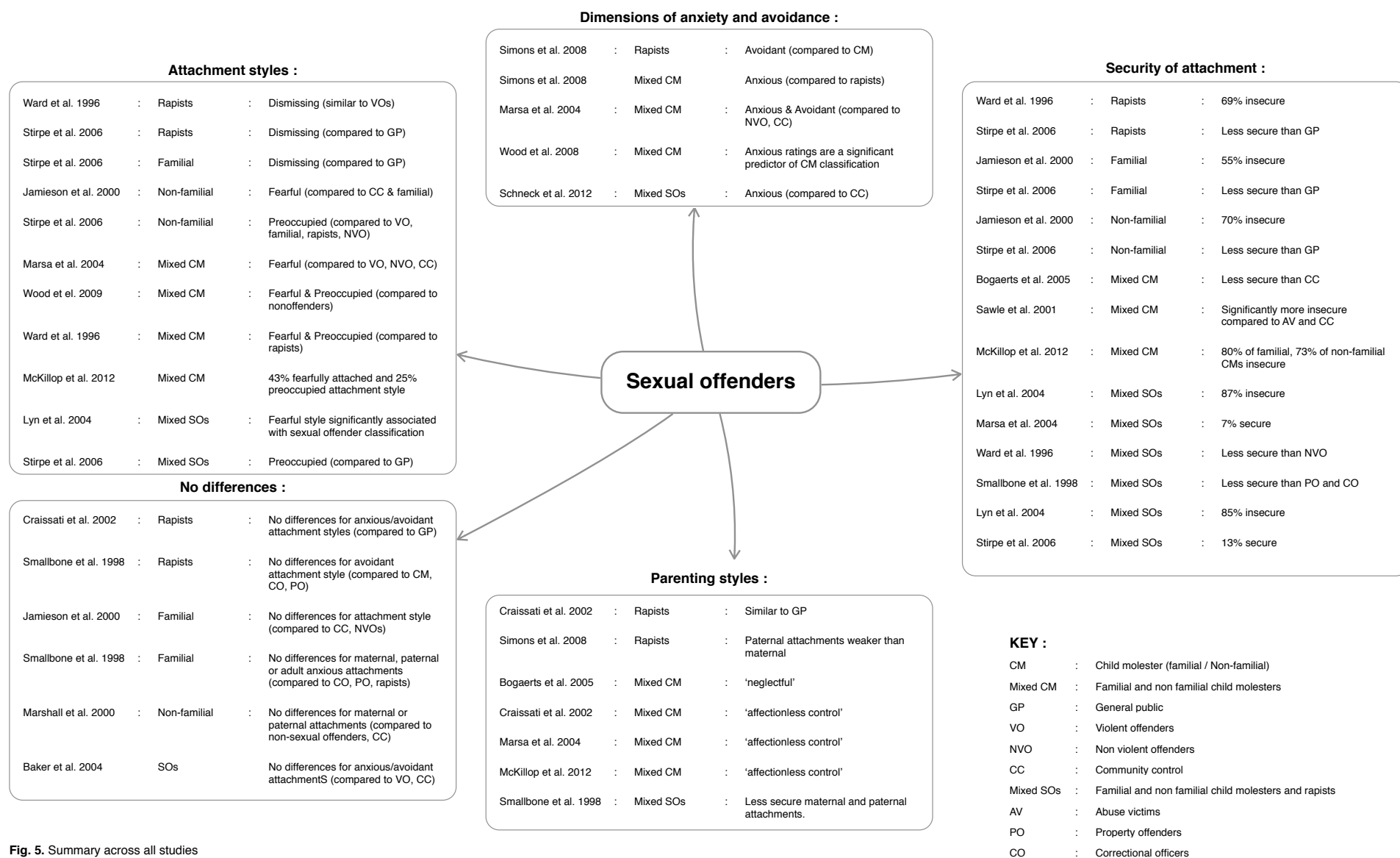


Fig. 5. Summary across all studies

Table 2. Criteria ratings for included studies.

Quality criteria

	Research question	Sample representation	Recruitment	Comparison groups	Group demographics	Exclusion criteria	Outcome measures	Analysis	Confound variables	Reporting of results	Literature	Limits	Overall score (/36)
Marsa et al (2004)	WC	AA	AA	WC	WC	AA	WC	WC	WC	AA	WC	WC	32 (88%)
Smallbone & Dadds (1998)	WC	WC	WC	WC	AA	PA	WC	WC	WC	AA	WC	AA	31 (86%)
Lyn & Burton (2004)	WC	WC	WC	AA	AA	PA	WC	WC	AA	AA	AA	WC	29 (80%)
Marshall et al (2000)	WC	WC	AA	WC	AA	PA	AA	WC	WC	AA	AA	PA	28 (77%)
Wood & Riggs (2008)	WC	AA	AA	AA	AA	PA	WC	AA	WC	AA	WC	AA	27 (75%)
Stirpe et al (2006)	WC	AA	AA	AA	WC	AA	AA	WC	PA	AA	WC	AA	27 (75%)
Wood & Riggs (2009)	WC	AA	AA	AA	WC	PA	PA	WC	AA	AA	WC	WC	27 (75%)
Baker & Beech (2004)	WC	NA	WC	WC	WC	AA	WC	AA	NR	NA	AA	WC	24 (66%)
Simons et al (2008)	WC	AA	WC	NA	NA	WC	AA	AA	AA	AA	WC	AA	24 (66%)
McKillop et al (2012)	WC	AA	WC	NR	NA	NA	WC	WC	NR	AA	WC	WC	22 (61%)
Sawle & Kear-Cowell (2001)	WC	AA	AA	AA	PA	PA	AA	AA	PA	AA	WC	PA	22 (61%)
Jamieson & Marshall (2000)	WC	PA	PA	WC	WC	PA	PA	WC	AA	AA	AA	NR	22 (61%)
Ward & Marshall (1996)	WC	NA	PA	AA	AA	PA	AA	WC	PA	AA	WC	AA	22 (61%)
Bogaerts et al (2005)	AA	PA	AA	AA	AA	NR	WC	WC	NR	AA	AA	AA	21 (58%)
Craissati et al (2002)	WC	WC	AA	PA	PA	PA	AA	AA	PA	AA	AA	AA	21 (58%)
Schneck et al (2012)	AA	PA	PA	AA	PA	PA	AA	AA	NA	WC	WC	AA	20 (55%)
Abracen et al (2006)	AA	PA	AA	AA	AA	NR	NA	PA	AA	AA	WC	NA	17 (47%)
Bogaerts et al (2006)	WC	NA	PA	PA	NA	NA	WC	AA	PA	AA	AA	AA	17 (47%)
Lu & Lung (2012)	X	X	X	X	X	X	X	X	X	X	X	X	NA
Lyn & Burton (2005)	X	X	X	X	X	X	X	X	X	X	X	X	NA
Hudson & Ward (1997)	X	X	X	X	X	X	X	X	X	X	X	X	NA
Note: WC = Well covered, AA = Adequately covered, PA = Poorly addressed, NA = Not addressed, NR = Not reported and NA = Not applicable.													

1. An appropriate and clearly focused question was posed
2. Participants were representative of the group being studied
3. Recruitment procedures were detailed
4. Control/comparison groups were included
5. Cases and controls were clearly defined and differentiated
6. Exclusion criteria stated
7. Appropriate outcome measure used
8. The statistics used were reported and appropriate
9. The main potential cofounders were identified and taken into account in the design and analysis
10. The results were well reported e.g. effect size, significant vs non-significant results discussed
11. Results are discussed in relation to the wider literature
12. Limitations of the study were discussed.

7. Discussion

7.1. General findings

This review focused on identifying, summarising and critically evaluating studies that have investigated attachment styles in sexual offenders. We sought to explore whether there is a relationship between sexually deviant behaviours and attachment style, specifically investigating whether associations exist between attachment styles and different types of sexual offending. We identified 16 papers comprising 1,486 participants all of whom were male. Of our sample 516 had committed a sexual offence against a child and 112 had committed a sexual offence against an adult and 103 had committed sexual offences against children and adults.

7.1.1. Childhood attachment relationships

Seven of the articles assessed childhood attachment styles using the Childhood Attachment Questionnaire (Marshall et al., 2000; McKillop et al., 2012, Simons et al., 2008 and Smallbone & Dadds, 1998) and the Parental Bonding Instrument (Bogaerts et al., 2005; Craissati et al., 2002; Marsa et al., 2004; McKillop et al., 2012). All of these studies included samples of child sexual offenders. Three classified prominent parenting styles as 'affectionless-control' (Craissati et al., 2002; McKillop et al., 2012; Marsa et al., 2004) and one 'neglectful' (Bogaerts et al., 2005). Smallbone and Dadds (1998) reported less secure maternal and paternal attachments for a mixed sample of sexual offenders (familial, nonfamilial, rapists) when compared with correctional officers and less secure maternal, but not paternal, attachments when compared to property offenders. Marshall et al. (2000) however used a sample containing only nonfamilial child molesters and reported that the dominant maternal attachment

style was secure with paternal attachment styles evenly distributed across secure, anxious/ambivalent and avoidant. Simons et al. (2008) reported no differences in maternal and paternal attachment scores for child molesters but higher avoidant attachment bonds in their rapist sample with paternal bonds significantly weaker than maternal attachments.

7.1.2. Adult attachment relationships

Twelve of the studies assessed adult attachment styles using a variety of measures (Baker & Beech, 2004; Bogaerts et al., 2005; Lyn & Burton, 2004; Jamieson & Marshall, 2000; Marsa et al., 2004; Mckillop et al., 2012; Sawle et al., 2001; Smallbone & Dadds, 1998; Stirpe et al., 2006; Ward & Marshall, 1996; Wood & Riggs, 2008, 2009) (See table 1. for full details of measures used). The eight studies, which separately reported on child molester samples, reported higher rates of insecure adult attachment among their samples (Bogaerts et al., 2005; Jamieson & Marshall, 2000; Marsa et al., 2004; Mckillop et al., 2012; Sawle et al., 2001; Stirpe et al., 2006; Ward & Marshall, 1996; Wood & Marshall, 2009). Rates of insecure attachment in child molester samples ranged from 93% (Marsa et al., 2004) to 70% (Jamieson & Marshall, 2000). Two studies combined individuals who had sexually offended against children and adults with varying results. Smallbone and Dadds (1998) found that sexual offenders were significantly more likely to report insecure attachment styles if compared with nonoffenders, but not property offenders. Lyn and Burton (2004) concluded that sexual offenders who had offended against both children and adults were more likely to report insecure attachment styles compared to rapists and nonsexual offenders. Baker and Beech (2004) explored attachment security in an adult only sex offender group (rapists) and did not report significant differences between sexual offenders, violent offenders and nonoffenders.

7.1.3. Attachment related anxiety and attachment related avoidance.

Based on the measures used, nine of the sixteen studies included in this review characterised their samples according to attachment anxiety and attachment avoidance dimensions (Smallbone & Dadds, 1998; Baker & Beech, 2004; Wood & Riggs, 2008; Marsa et al., 2004; Simons et al., 2008; Sawle et al., 2001; Stirpe et al., 2006; Schneck et al., 2012 and Bogaerts et al., 2005). Smallbone and Dadds (1998) and Baker and Beech (2004) showed no differences for the anxiety or avoidance attachment subscales for samples of child molesters and rapists. Wood and Riggs

(2008) however showed that attachment anxiety was a significant predictor of child molester categorisation but attachment avoidance was not. Marsa et al. (2004) similarly demonstrated greater levels of interpersonal anxiety and avoidance in sexual offenders when compared with nonviolent offenders and a community control group. Simons et al. (2008) found significantly more anxious attachment bonds in their child molester group compared with rapists. In contrast the rapist group demonstrated higher avoidant attachment scores. Sawle et al. (2001) found that child molesters scored low on Confidence and high on Relationship as Secondary indicating negative views of self and others (anxious and avoidant). Stirpe et al. (2006), using the AAI, reported that familial offenders and rapists had a higher percentage of Unresolved State of Mind classifications than the general population. Schneck et al. (2012) did not report what type of sexual offences their sex offender group had committed but reported increased anxious attachment styles for their sexual offender group and comparable rates of avoidant attachment styles compared to a community sample. Perhaps helpful in deciphering the variable results was Bogaerts et al.'s. (2005) study, which explored the impact of personality disorder and found that those with a personality disorder are significantly more likely to report avoidant and anxious-ambivalent current adult attachment styles.

7.1.4. Types of insecure attachment relationships

Eight studies classified participants using a distinct style of attachment (e.g. secure, preoccupied, fearful and dismissing). The results for the child molester samples were mixed between classifications of fearful and preoccupied attachment styles. Four studies, using mixed samples of intrafamilial and nonfamilial child molesters, identified reports of fearful (Marsa et al., 2004; McKillop et al., 2012) and fearful or preoccupied (Ward & Marshall, 1996; Wood & Riggs, 2009) attachment styles. Stirpe et al. (2006) and Jamieson & Marshall (2000) explored intrafamilial and nonfamilial child molesters separately. Stirpe et al. (2006) found that nonfamilial child molesters reported a higher percentage of preoccupied classifications with intrafamilial offenders reporting a higher level of dismissing attachment styles compared to the general public. Jamieson and Marshall (2000) reported higher frequencies of fearful attachment styles for nonfamilial child molesters with no differences between intrafamilial child molesters and community and nonsexual offender groups. Lyn and Burton (2004) using a sample that contained both child and adult sexual offenders reported that a fearful attachment style was significantly related to having a history of sexual offending. Ward and Marshall (1996) and Stirpe et al. (2006) explored the attachment styles of adult sexual offenders separately and categorised

participants incarcerated for rape as reporting a higher frequency of dismissing attachment styles.

7.2. Strengths and limitations of review

The strengths of this review included the systematic search strategy used, the exclusion of non-clinical data and a focus on studies using a well-validated measurement tool. A number of measures were also employed to limit the potential bias of this review. In the first instance authors of selected studies were contacted to determine their knowledge of any unpublished works in this field. In conjunction with this an independent second rater scored 50% of the papers during the quality assessment stage. A limitation of this review pertains to the search parameters, which were entered in English and may therefore have resulted in a publication or language bias. The quality assessment tool may be viewed as a second limitation of this review as it was established specifically for this review and despite being based on previously well validated measures and standards (Tarrier & Wykes, 2004; Rosenthal, Rosnow & Rubin, 2000) it itself is not validated. This assessment tool also allocated equal weightings to each criterion, which maintained consistency with other assessment tools and enabled uniformity across the tool. However weighting each criterion equally may have reduced some articles overall scores despite perhaps having stronger methodologies. For example a rating of 3 for the 'research question is clearly stated' criteria and a rating of 1 for the 'appropriate measures used' criteria would result in a comparable overall score for a paper which scored a 1 for 'research question is clearly stated' criteria and 3 for 'appropriate measures used'. This may be viewed as problematic with the use of appropriate measures perhaps deemed to be more important than the clarity of the research question in the assessment of a studies quality.

7.3. Strengths and limitations of the papers

The first limitation of the articles included in this review relates to the type and size of samples used. Many of the studies obtained relatively small sample sizes given the difficulty in obtaining large samples of sexual offenders (Marsa et al., 2004 and Smallbone & Dadds, 1998). Power calculations were only reported by one study (Schneck et al., 2012) leaving the required amount of participants needed for a medium effect size to be obtained unknown. The majority of studies used participants who took part voluntarily. This may have biased the samples towards individuals who seek attention and approval possibly reflected in the reports of high

levels of fearful attachment styles (Lyn et al., 2004). Individuals with fearful attachment styles fear rejection but desire closeness with others and therefore may present as more compliant with an eagerness to please. Equally individuals with a dismissive attachment style are less likely to voluntarily participate in a study and may account for the lower rates of dismissive attachment style reported by these studies (Lyn et al., 2004). The use of convenience sampling also diminished the degree to which the samples included in these studies can be said to be representative of the sexual offending population.

Across the 16 studies, 11 different measures of attachment were used to varying degrees; ECRI was used by 25% of the studies, CAQ by 25%, RSQ by 15%, PBI by 20%, RQ by 10%, AAS by 5%, ECR-R by 5%, AAI by 5%, ECR by 5%, ECRI-State by 5% and the ASQ by 5%. The use of self-report questionnaires and semi-structured interviews of attachment may be viewed as both strengths and limitations. While demonstrating strong predictive validity (Crowell, Waters & Treboux, 1996; Fonagy, Steele & Steele, 1991) the AAI is time intensive to train in and takes considerably longer to administer. Self-report questionnaires are easier and faster to administer enabling larger samples however they can be subject to bias from the attachment system itself with individuals who are avoidant of attachment tending to self-report as secure (Gumley, Taylor, Schwannauer & Macbeth, 2013). Participants may also choose not to complete all sections of a questionnaire nullifying their use and reducing sample size (Lyn & Burton, 2004). As with all self-report measures the potential exists for participants to under report the frequency, severity and nature of offences and past experiences. Underreporting reduces the risk of false positives but it also potentially suppresses significant associations. It is also difficult to determine the accuracy of recollections regarding childhood experiences and attachments when using self-report measures. Many studies included a measure of social desirability however participants may still be subject to defensiveness or other self-serving biases. In this respect interview based measures may be more suitable to determining the veracity of accounts. Studies could have accounted for these issues by using both self-report and informant reported measures of attachment were possible (Arbuckle, Berry, Taylor & Kennedy, 2012; Berry, Barrowclough & Wearden, 2008).

Some reporting problems were further identified including a lack of clarity when distinguishing between types of sexual offenders with some results pertaining to mixed samples of participants who had sexually offended against children and adults (Bogaerts et al., 2005; Lyn & Burton, 2004) and some clearly differentiating between intra and nonfamilial child molesters and rapists (Mckillop et al., 2012;

Stirpe et al., 2006). Some studies also provided detailed accounts of offending history and demographic variables for both the sexual offender and comparison groups (Marsa et al., 2004) whereas others provided only sparse information (Sawle & Kear-Colwell, 2001). Sexual offenders may have a history of violent as well as sexual offences and may not present with an exclusive pattern of behaviour. Without sufficient descriptive information about samples under investigation conclusions may be inaccurately appropriated. Further reporting difficulties related to inclusion and exclusion criteria with a number of the studies not reporting on their exclusion criteria (Wood & Riggs, 2008) and providing minimal information regarding the criteria used to identify suitable participants (Jamieson & Marshall, 2000). In particular information regarding previous treatment was often missing. At times these reporting issues made reaching a conclusion more difficult.

7.4. Implications for further research

Attachment theory has established itself as one of the most influential contemporary conceptual frameworks for understanding emotion regulation (Mikulincer, Shaver & Horesh, 2006). Given the importance of attachment theory as a framework for understanding coping and emotion regulation it is important that research develops to enhance our understanding of how attachment shapes sexual offending overtime and implicates itself into how individuals relate to services and treatment programs. It would appear that a relationship has been established between attachment and sexual offending in bivariate comparisons between sexual and nonsexual offenders. Further research is needed in clarifying causal relationships however that can contribute to information about the causes of sexual offending and how it can be prevented. Longitudinal studies, based upon existing knowledge of associated factors such as childhood trauma, appear to be most appropriately placed to provide such information. Equally the use of regression models and path analyses may be beneficial in accommodating reports of multiple offences (violent and sexual) thus providing predictive value. The development of existing self-report measures would lessen the reliance on interview-based measures, which currently require extensive training and data collection periods making them prohibitive for research requiring larger samples sizes or repeated administrations.

Research investigating the stability of attachment from childhood to adulthood is also required to ascertain whether retrospective reporting is a meaningful way to establish attachment style. Mckillop et al. (2012) demonstrated weaker than expected relationships between child and adult attachment style indicating that while an insecure adult attachment may have been preceded by a

secure childhood attachment, secure adult attachments are not generally preceded by insecure childhood attachments. Childhood attachment problems also appear to be most clearly reflected in adult state attachment as opposed to adult trait attachments (Mckillop et al., 2012). This instability in attachment vulnerability would be an interesting avenue for future research given the proposition that attachment problems may re-emerge in the context of relationships or other life problems and often precipitate sexual abuse behaviour (Mckillop et al., 2012). To facilitate this future research should include samples that more closely represent the wide range of sexual offenders. The dominant use of prison populations results in conclusions related to offenders who have committed frequent and severe sexual offences. Including a combination of community and incarcerated participants would enable a more accurate representation of the range of sexual offenders and offences (Lyn et al., 2004).

7.5 Implications for clinical practice

Despite methodological limitations, the studies included in this review used well-validated assessment measures with suitable samples, which enabled an exploration of the two aims of this review, firstly to explore whether there is a relationship between sexually deviant behaviours and attachment style and secondly to explore whether there is a difference in attachment styles between types of sexual offending. It would appear that individuals who have sexually offended against children demonstrate more insecure childhood maternal and paternal attachments alongside higher rates of insecure adult attachment styles. Insecure attachment styles appear to have been predominantly identified as preoccupied and fearful for child molesters with familial offenders and rapists classified as dismissing. A more variable picture was apparent concerning offenders who have sexually offended against adult victims, as were conclusions based on attachment anxiety and attachment avoidance dimensions. The results outlined in this review have implications for clinical practice in developing an understanding of individuals' offending behaviour and engagement with services.

Attachment style would appear to form an integral role in the development of child molestation (Bogaerts et al., 2006). Through the introduction of interpersonal tools into therapy and the experience of intersubjective relationships, therapists can assist individuals in developing an understanding of their attachment histories. As demonstrated by Sawle and Kear-Colwell (2001) who reported a deepening of offenders' understanding of attachment histories with an interpersonal focus to cognitive analytic therapy and a positive relationship. Developing insight into how

attachment relates to inappropriate sexual behaviours can be facilitated across many levels of intervention including helping individuals to self identify attachment insecurities to preserving appropriate interpersonal boundaries and establishing socially appropriate ways of meeting unmet attachment needs. The development of early intervention and preventative models may offer further advantages. Olds (2002) demonstrated that perinatal attachment focused interventions with disadvantaged mothers reduced both childhood maltreatment and later involvement in delinquent behaviours. The results by Mckillop et al. (2012) also suggested the importance of paternal relationships suggesting that strengthening attachments or the remediation of attachment problems with fathers may reduce vulnerabilities related to later sexual offending.

An appreciation of attachment status by therapists is also of clinical importance. Many clinicians utilise the attachment model to facilitate their work with other populations such as traumatised adults (Kohlenberg & Tsai, 1998) and borderline personality disorder (Fonagy, Target & Gergely, 2000) but often not with sexual offenders (Blanchard, 1998). As with many others, Blanchard (1998) posited that the importance of the therapeutic relationship is of the same value as the behavioural, cognitive and physiological interventions available for sexual offenders. He felt however that due to the nature of the crimes committed the development of effective therapeutic relationships is often hindered. An awareness and appreciation for the integral role attachment status plays in sexually deviant behaviour will enable clinicians to anticipate relational dynamics that may emerge throughout treatment and avoid the inadvertent perpetuation of unhealthy adjustment dynamics and boundary violations (Lyn & Burton, 2004). The therapeutic relationship itself can then be used as a tool to facilitate change. A strong therapeutic relationship will enable individuals the stability and confidence to work through previous relationships and develop more adaptive appropriate responses. Understanding the influence attachment profiles have on an individuals' ability to engage and similarly how staff interact with individuals during treatment can potentially strengthen the therapeutic alliance and assist in reducing recidivism.

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Chapter 3. Journal Article

Delivering group treatment to sex offenders: An Interpretative Phenomenological Analysis of impact.

Abstract

Despite extensive research investigating the impact of traumatic exposure on therapists who work with victims of sexual abuse the literature exploring the impact on those working in the forensic field with individuals who have committed sexually abusive acts remains in its infancy (Clark and Roger, 2007). Delivering treatment to individuals who have sexually offended has been shown to result in powerful and intense reactions in therapists (Maslach, Jackson, and Leiter, 1996; Rich, 1997) however there is an emerging body of literature which demonstrates that a large percentage of treatment providers do not report negative psychological effects but undergo positive transformative processes (Kadambi and Truscott, 2003; Dreier and Wright, 2011; Hernandex, Engstrom and Gangsei, 2010). The aim of this study was to add an explicitly more phenomenological understanding of the experiences of therapists. Semi-structured interviews were conducted with 9 sexual offender group treatment facilitators and analysed using Interpretative Phenomenological Analysis (IPA). The analysis revealed two superordinate themes: 'balancing act' and 'managing dysfunction'. These themes are unpacked revealing both positive and negative impacts of this role highlighting that while deleterious and challenging effects are apparent, individuals benefit personally and professionally from working in this field. The use of IPA allowed an appreciation of individual experiences and highlighted the rewarding aspects of this profession as well as the more challenging features.

Keywords: Offenders, therapist experience, distress, resiliency, Interpretative Phenomenological Analysis.

It has been acknowledged that working therapeutically with individuals who have experienced physical or emotional harm can be challenging. Having to listen to accounts of a traumatic event or even having detailed knowledge of an event have been shown to cause prolonged anxiety in varying degrees (American Psychiatric Association, 2000; Eriksson, Vande Kemp, Gorsuch, Hoke & Foy, 2001). The impact of traumatic exposure on therapists who work with victims of sexual abuse has been extensively studied however the literature exploring the impact on those working with individuals who have committed sexually abusive acts is only beginning to develop (Clark & Roger, 2007). Some research has suggested that the challenges of therapeutic work extend to those providing treatment to perpetrators of abuse as well as victims (Moulden & Firestone, 2007; Ennis & Horne, 2003). Delivering treatment to sexual offenders has been demonstrated to exert a powerful impact on therapists resulting in a range of symptoms such as cognitive intrusions in the form of flashbacks, nightmares and images, changes in mood (Rich, 1997) and symptoms of avoidance (of people and places) (Way, VanDeusen, Martin, Applegate, & Jandle, 2004; Rich, 1997; Atkinson-Tovar, 2003). Additionally therapists have reported a loss of trust and innocence (Bengis, 1997; Ellerby, 1997; Jackson, Holzman, Barnard & Paradis, 1997; Rich, 1997) and a reduction in feelings of safety relating to other people and to the world in general (Freeman-Longo, 1997; Jackson et al., 1997). The emphasis of research in this area has therefore been to explore and determine the negative psychological impact on therapists (Farrenkopf, 1992; Hatcher & Noakes, 2010; Maslach, 1982; Maslach & Jackson, 1981, 1986; Figley, 1995; Pearlman & Saakvitne, 1995). To fully understand the psychological impact of this specialised role however both the potentially negative and positive effects need to be explored.

The rehabilitation of offenders employs a systems approach so that work with offenders takes place while in custody and on release to the community involving the offender, their families, significant others and statutory and voluntary organisations (Gobbels, Ward & Willis, 2012). Rehabilitation work is based on theories such as the strengths based model, the Good Lives Model (GLM; Ward & Maruna, 2007) and the Risk Need Responsivity Model (RNR; Andrews & Bonta, 2010). Treatment programmes for sexual offenders have evolved over the past 30 years progressing from behaviourally based programmes (Abel, Levis, & Clancy, 1970; Marshall, 1973) to more intricate cognitive behavioural programs (Marshall, Anderson, & Fernandez, 1999; Marshall, Fernandez, Hudson, & Ward, 1998). Initially these behaviourally orientated programmes were designed to be highly prescriptive with the underlying inference being that therapists delivering the programmes had little or no influence over behaviour change (Ward et al., 2012). Some current research appears to be demonstrating that reoffending rates are reducing with reviews by Marshall and Anderson (1996) and Marshall et al.

(1999) and a meta-analysis by Hanson (2000) indicating that sexual offender treatment is effective in reducing recidivism. The cause of this reduction is unclear (Andrews & Bonta, 2010; Laws & Ward, 2011) with numerous factors associated with desistance including age, social support, employment, education, prison, cognitive transformation and intimate relationships (Göbbels, Ward & Willis, 2012; Laws & Ward, 2011).

More recently interest has developed into exploring the influence of the interaction between therapists and clients within the context of cognitive behavioural programs (Schaap, Bennun, Schindler, & Hoogduin, 1993). With treatment effectiveness varying considerably across programmes it has been proposed that differing therapeutic styles and abilities in creating optimal therapeutic environments may be involved (Marshall & Serran, 2000). The available research on process variables and therapists' characteristics indicates that the behaviours of a therapist have a powerful influence on the outcome of treatment irrespective of the intervention (Marshall, Fernandez, Serran, Mulloy, Thorntonc, Mann & Anderson, 2003). The therapist-client relationship has been demonstrated to account for approximately 25% of treatment variance (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982) with an effect size of .22 evidenced in a meta-analysis by Martin, Garske & Davis (2000). Therapists who are perceived as understanding and interested, who instill hope and offer encouragement have been reported to be the most helpful in treatment (McLeod, 1990). The interpersonal relationship and skills of the therapist then are viewed by many to be pivotal to effective treatment outcomes (Beck, Rush, Shaw, & Emery, 1979; Egan, 1998; Frank, 1971; Frank, 1973; Frank, 1978; Kleinke, 1994; Kohut, 1990; Kozar & Day, 2012; Lambert, 1989; Luborsky, 1984; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Rogers, 1975; Rogers, 1961; Strupp, 1982; Yalom, 1980).

It is generally agreed that sexual offenders present a unique set of characteristics, which may impact upon the clinician compared with other populations (Edmunds, 1997; Farrenkopf, 1992, Marshall & Burton, 2010). Attributes such as lower levels of motivation (Tierney & McCabe, 2002; Ellerby 1997; Mitchel & Melikian, 1995), the mandated nature of their attendance for treatment (Strasburger, 1986) and the necessary recounting of sexually explicit and deviant behaviours (Clarke 2004; Turner, 1993; Mann & Webster, 2002) have been highlighted as features which may increase the potential negative effects of working with this population and impact the therapeutic alliance. Clinical characteristics including diagnoses of personality disorder (Deutsch, 1984) and the presence of chronic and complex mental health presentations may also lead a therapist to feel deskilled and incompetent (Figley, 1993). The fact that some sexual offenders have experienced sexual abuse themselves requires clinicians to additionally acknowledge them as victim and perpetrator (Kearns, 1995). The nature of the therapy with

perpetrators can itself present further challenges for treatment providers with sex offender therapists residing in a mostly counter-attitudinal position whereby they are required to manage the responsibilities attributed to their professional role while moderating their personal feelings towards the clients' offences (Lea, 1999). Practitioners working in forensic settings may also be faced with a dual relationship problem in having to deal with the ethical rules and norms relating to community protection and legal systems as well as the ethical norms relating to the offender's well being and autonomy (Ward, 2013). With many practitioners having their roots in mental health or allied disciplines internal conflict can arise when trying to marry forensic and correctional work (Ward, 2013). Treatment providers may find themselves in opposition to societal value systems as evident in Ellerby, Gutkin, Smith and Atkinson's (1993) study in which 70% of sex offender treatment providers reported feeling uncomfortable and needing to justify their work, and 90% described negative reactions from others. The perceived pressure to rehabilitate offenders may also impact a therapist's sense of efficacy with the often found discrepancy between therapists' and societies' expectations and offenders' subsequent actions leading to feelings of helplessness, guilt and personal questions of ability (Kearns 1995).

When providing treatment to sexual offenders then, therapists are posed with the dichotomy of creating an open and therapeutic environment for their clients, while concurrently managing these challenging characteristics and holding awareness of offence history. In addition for any therapeutic relationship to endure and assist in effecting change therapists must also empathetically engage with clients requiring clinicians to experience and identify with accounts as if they had encountered the feelings first hand (Figley, 1995). For therapists working with sexual offenders this can entail listening to accounts of explicit, sexually abusive information which may result in strong emotional and cognitive countertransference responses (Bengis, 1997; Kearns, 1995). Various concepts have been mentioned in the impact literature, which pertain to the negative transformative impact a therapists' work can result in (Maslach, 1976, 1982; Maslach & Jackson, 1981, 1986; Figley, 1995; Pearlan & Saakvitne, 1995). Vicarious trauma has been defined in a number of ways under many different names such as secondary victimization, contact victimization, compassion fatigue and secondary traumatic stress (Lugris, 2000) with current literature indicating that delivering treatment to individuals who have sexually offended can result in cognitive, behavioural and emotionally negative consequences (Clarke, 2011).

Despite the literature's focus on the deleterious effects of working with sexual offenders the presence of vicarious trauma responses among treatment providers appears to be variable as opposed to inevitable (Hatcher, 2012). There is a growing

acknowledgment within the literature that not all therapists respond in similar ways and many may undergo positive as opposed to negative processes when working with clients (Kadambi & Truscott, 2003; Dreier & Wright, 2011; Hernandex et al., 2010). Recent studies, are in agreement with Farrenkopt's (1992) original assertion that only a fifth to a quarter of treatment providers report negative effects by indicating that more than three quarters of sex offender treatment providers do not report negative psychological effects (Kadambi & Truscott, 2003; Dreier & Wright, 2011; Hernandex et al., 2010). Therapists have reported gaining meaning and reward through observing changes in offenders, perceiving their involvement in protecting society and working closely with colleagues (Kadambi & Truscott, 2006). Scheela (2001) demonstrated that positive affect was gained through teamwork, witnessing positive client change and, as with Dreier and Wright (2011) and Kadambi and Truscott (2006), a sense of being involved in protecting the community. Turner (1993) and Ellerby (1998) showed that the majority of respondents working in sex offender treatment programmes reported an enhanced sense of achievement and personal accomplishment following their involvement in facilitating on programmes. The experience of an increased sense of competency and closeness to co-workers and supervisors was additionally evidenced by Dreier and Wright (2011) and Dean and Barnett (2011).

These contradictory accounts pose the question as to why there is so much variability in reports of symptoms of vicarious traumatising and why some treatment providers appear to be psychologically resilient to the challenges of being frequently exposed to traumatic material. Some of the inconsistency may be explained by deficiencies within the existing research. Firstly, and most notably absent from existing research, is an appreciation of individual differences among treatment providers and how certain characteristics may be involved in enhancing resiliency or alternatively exacerbating psychological vulnerabilities (Clarke, 2011). If the nature of the work was itself responsible for the negative responses indicated above it would perhaps be expected that all individuals who deliver treatment to sexual offenders would be subjected to similar deleterious effects but this is not the case. There has however been surprisingly little attention paid to the characteristics of individual treatment providers and the role these factors may play in influencing impact. By acknowledging individual differences a number of investigators have combined features of the individual and features of the situation to better explain the mechanisms behind symptoms of distress. The Model of Dynamic Adaptation (Clarke, 2004, 2008; Clarke & Roger, 2002, 2007) was developed to categorise factors that may be involved in moderating or exacerbating the negative effects or equally enhancing the positive effects so as to contribute to the prediction of risk (Grove & Meehl, 1996). Frameworks such as this have not been widely used in exploring

sex offender treatment provider impact and may be beneficial in clarifying some of the inconsistencies supporting individual well-being.

Further, endemic in studies in this field, is the conceptualisation of therapist impact within existing frameworks from similar areas such as trauma and victim research. While comparable, linking these fields encourages the use of assessments and measures developed for a conceptually similar but distinct population. The normative data established for these assessments relates to a different group and therefore could be said to preclude meaningful comparisons (Clarke 2011). In addition conceptualising therapist impact within existing frameworks fosters the adoption and application of terms such as vicarious trauma as fixed inevitable outcomes of working with distressing information. Used in this way such terms may serve to over pathologise what is perhaps a normal process of adaptation and prevent individuals' experiences as being viewed along a continuum (Clarke, 2011). Ellerby (1998) has argued that viewing distress as inevitable as opposed to a continuum deters the use of objective measures of distress and may impede exploration of factors, which may moderate individual impact. A final limitation of the current literature is that it has been predominantly one sided with a focus on the negative effects of working with this client group despite a number of studies referencing the high levels of satisfaction treatment providers report experiencing in their work (Kadambi and Truscott, 2006). The absence of individual differences, the tendency to compare the impact of sexual offender treatment with similar but distinct fields and the nearly exclusive focus on the challenges of working with this population have led to inconsistencies in the literature and hindered an understanding as to why variability exists in reports of symptoms of vicarious traumatisation and psychological resiliency.

The literature to date demonstrates the challenges of delivering treatment to this client group highlighting the risk of powerful and intense reactions in therapists. However more recent literature has also shown that facilitators in this field experience their work as highly rewarding and satisfying (Kadambi & Truscott, 2006) suggesting paradoxically that working with sex offenders can be simultaneously rewarding and distressing (Turner, 1993). It is becoming apparent that exposure to frequent accounts of sexually offensive acts does not inevitably lead to pathological outcomes but that there is a complex interplay of factors that can tip the scales in either positive or negative directions. Researchers have become increasingly interested in exploring the factors involved in the personal transformations therapists may encounter to enable a multifaceted understanding of the ways in which not only the therapeutic relationship but also a therapist's sense of self are impacted by working with sexual offenders and in dealing with traumatic material (Hernandez et al., 2010, Clarke, 2011). The aim of this study is to add an explicitly more phenomenological understanding of the experiences of

therapists by asking, “what was it like delivering treatment to individuals who have committed sexual offences?”. Through a detailed and rigorous analysis of participants’ responses using Interpretative Phenomenological Analysis (IPA) an insight into the cognitive and affective responses provides a rich and detailed understanding of experiences. The purpose here then is not to explicitly explore the presence or absence of vicarious trauma symptoms or to measure an individual’s level of resiliency but to offer a more fine grained phenomenological understanding of participants’ individual experiences to enhance our understanding of the many factors involved in influencing how treatment providers are impacted by their work.

Method

Participants. Individual interviews were carried out with 10 participants who were recruited using a non-probabilistic, purposive sampling strategy. This form of sampling was employed as it provides the most efficient method of selecting information rich cases to facilitate an in depth phenomenological understanding of this issue (Patton, 2002). To participate individuals were required to be sexual offender group treatment facilitators and be either qualified social workers, psychiatric nurses or clinical/forensic psychologists, have one or more years experience working with this population, have been qualified for more than one year and have a good understanding of English and provide consent. Individuals involved in the development and running of sexual offender treatment programmes who were not directly involved in their delivery were not eligible to take part. Participants were recruited from a maximum-security hospital and two criminal justice teams. Participant characteristics are displayed below (Table 3).

Table 3. Participant demographics.

Participant	Age	Designation	Working with SOs	Delivering Group Treatment	% of Caseload Involving SOs
1	45-49	Social Worker	5.5 years	3 years	50%
2	45-49	Senior Staff Nurse	5 years	5 years	40%
3	40-44	Forensic Psychologist	14 years	8 years	70%
4	50-54	Senior Charge Nurse	33 years	8 years	30%
5	45-49	Senior Staff Nurse	29 years	0 years	30%
6	30-34	Clinical Psychologist	6 years	5 years	90%
7	30-34	ANP	4 years	4 years	20%
8	30-34	Social Worker	1 year	1 year	30%
9	60-64	Senior Social Worker	14 years	8 years	90%
10	55-59	Nurse Therapist Lead	8 years	8 years	25%

Note: SO = sexual offender, ANP = advanced nurse practitioner.

All participants received individual and group supervision and engaged in debriefing sessions with their co-facilitators at the end of each group. One participant was removed from the study due to insufficient experience delivering group programmes having only recently completed training (participant 5). The remaining nine interviews were included in the analysis. Six of the therapists were women and three were men. In alignment with IPA methodology, the sample was small so as to enable a detailed analysis of each case (Smith et al., 2009). Ethical approval was granted by the University of Edinburgh and the maximum-security hospital in accordance with the ethical code of the British Psychological Society (2009).

Materials. The interview consisted of open-ended questions designed to explore how therapists had experienced delivering group treatment to people who had sexually offended. The aim of this study was to extract each participant's experiences of being a sexual offender treatment provider and as such the interviews were semi-structured. A general set of questions, in the form of an interview schedule, was flexibly used to facilitate conversation. Questions were kept descriptive (could you tell me about your job), narrative (can you tell me how you came to have your current job), structural (what is involved in your job), contrasting (what are the main rewarding/challenging aspects of your role), evaluative (how do you feel at the end of the groups) and comparative (how do you think you would feel if you did not work in your current role). Prompts (can you tell me a bit more about that) and probes (what do you mean by a 'tough group') were also used to extract additional details if needed. Over-empathetic (that must be really difficult to deal with), leading (you probably find it hard to switch off afterwards) and closed questions (so you enjoy your work) were avoided.

Procedure. In the first instance the managers of the therapy lead treatment teams at the maximum security hospital and the two criminal justice teams were approached and members of the team contacted to determine their interest in participating. Participants were provided with an informed consent form and instructed that their participation was voluntary and they were able to withdraw at any time. Prior to the interview a brief questionnaire for recording demographic information was sent to each participant to be completed before the interview. In line with previous research the demographic information collected referred to participants: age, qualification, profession, years of experience working with sexual offenders, years of experience delivering the sexual offender group treatment programme and percentage of caseload dedicated to sexual offender work. All interviews were carried out at the participants' place of work and

audio recorded for later transcription. Each participant was interviewed once and the interviews lasted approximately 60 minutes.

Analytic process. Within qualitative methodologies there are numerous approaches originating from a variety of traditions and theoretical dispositions (Yardley, 2000). This study used an approach embedded within a phenomenological framework involving a detailed examination of an individual's world in an attempt to explore subjective perceptions and accounts of events as opposed to being aimed at developing an objective statement of the event itself (Smith & Osborn, 2007). Interpretative Phenomenological Analysis (IPA) is a phenomenological approach rooted in the philosophical viewpoint of individuals such as Heidegger, Merleau and Ricoeur who posit that meaning is itself created and comes into existence through interpretation, discussion, action and interaction (Kvale, 1983; Ray, 1994). As such IPA emphasizes that both interviewee and the researcher have fundamental roles in the process and must engage dynamically in a process of interpretative activity whereby the interviewee is attempting to make sense of their world and the researcher is attempting to make sense of the interviewee attempting to make sense of their world. IPA acknowledges that what people say is connected to how they feel and think and is described as having cognition as a central analytic concern (Smith & Osborn, 2007). Thus IPA is primarily concerned with exploring, in detail, how individuals are making sense of their personal and social world (Smith & Osborn, 2007). As this study is interested in determining the ways in which a group treatment facilitator is impacted through providing treatment to sexual offenders, an approach which views the participant as an, "experiencing, meaning-making, embedded and discursive agent" (Eatough & Smith, 2006, p. 486) was deemed most appropriate. Analysis was guided by previous studies (Storey, 2007; Smith & Osborn, 2003) and the formal template for performing IPA as set out by Smith, Flowers and Larkin (2012). A number of stages were therefore followed and listed below (Table 4).

Table 4. Stages followed during analysis.

Stage	Procedure
Stage 1	Reading and re-reading of transcripts.
Stage 2	Initial noting Words, comments and initial ideas were listed in the right hand margin of the transcript. Three levels of notes were made: descriptive, linguistic and conceptual.
Stage 3	Developing emergent themes The initial notes were used in this stage rather than the transcript itself. In the left hand margin the extracted words, comments and ideas listed in the right hand margin were transformed into emergent theme titles (concise phrases), which

	aimed to capture the essential quality of what was found in the text.
Stage 4	<p>Searching for connections across emergent themes</p> <p>The emergent themes were listed separately and examined for connections and disparities. This clustering of themes was checked against the original transcript to ensure they were an accurate reflection of the transcript. Direct quotes from the transcripts were attached to each theme to ensure that the original meaning of the theme was not lost in the interpretation. These themes were then formulated into super-ordinate themes made up of sub-ordinate themes and a table of master themes compiled.</p>
Stage 5	<p>Moving to the next case</p> <p>Stages 1-4 were repeated across the other transcripts</p>
Stage 6	<p>Looking for patterns across cases</p> <p>All themes were laid out to explore patterns i.e. are there connections between the themes and do any themes help to elucidate themes from other transcripts. Themes were organised as to which were the most important.</p>
Stage 7	<p>Taking it to deeper levels of interpretation</p> <p>Themes were translated into a narrative account. Themes were chosen to focus on based on prevalence but more so on the richness of particular passages that highlight the theme and how the theme illuminates other aspects of the account.</p>

Many of the traditional quality controls applied to quantitative investigations are not applicable to qualitative research (Yardley, 2000). Given that qualitative investigations are becoming more widespread in clinical and health care research however (Cohen & Crabtree, 2008) a number of guidelines have been developed for judging and ensuring the quality of qualitative studies (Mays & Pope, 2000). Cohen and Crabtree (2008) conducted a review of published criteria relating to qualitative research, developing a set of criteria against which studies should be measured. According to this criteria studies should be: 'ethical, pragmatically and theoretically important, clearly and coherently articulated, and use appropriate and rigorous methods' (Cohen & Crabtree, 2008). As with quantitative research, investigations should be carried out in a respectful, humane and honest way ensuring empathy, collaboration and service objectives. A consensus has not been reached regarding the extent to which concepts of validity and reliability should be applied to qualitative research (Cohen & Crabtree, 2008; Mays & Pope, 2000). This is unsurprising given the inherent differences in the aims of qualitative research compared with quantitative studies. With the former focused on exploring the subjective interpretations of participants and the latter focused on determining objective measures of knowledge and reducing error (Johnson, Long & White, 2001). However methods of ensuring quality in qualitative research are necessary if studies are to have practical and theoretical use. With reference to ensuring and improving quality the standards identified by Smith (2011) were adhered to whereby the study aims to i) have a clear focus, ii) be based on strong data derived from developed interviewing skills, iii) present rigorous analysis with

measures of prevalence and extract selection provided, iv) provide sufficient theme elaboration, and v) employ interpretative commentaries which highlight existing convergence and divergence of experiences. To assist with issues more related to reliability; peer review and debriefing were used and have been identified as exemplifiers of quality in qualitative research (Waitzkin, 1979).

Results

During the analysis of each participant's transcript using IPA (Smith & Osborn, 2003) themes which occurred in at least half of the other transcripts were categorised as recurrent so as to promote an idiographic perspective (Dickson, 2008). The extracts presented in this section were selected because they best represent these recurrent themes and because they provide the best exemplars of a given theme. This article presents two recurrent superordinate themes, each with three recurring subordinate themes (Table 5). The order in which the themes are presented has been chosen to reflect their apparent importance in participants' experiences of delivering treatment to sexual offenders.

Table 5. Distribution and prevalence of themes across participants.

Superordinate Theme	Subordinate Theme	Occurrence of theme by participant									
		1	2	3	4	5	6	7	8	9	
Balancing Act	Finding somewhere to belong	x	x	x	x	x	x	x	x	X	
	Pushing personal boundaries	x				x	x		x	x	
	Guardians of the patients and the public	x	x	x	x		x		x	x	
Managing Dysfunction	What’s happening to me?			x	x	x		x		x	
	The consummate professional		x			x	x	x	x	x	
	Frustrations of a complex populaton	x	x	x				x	x	x	

Superordinate theme 1: Balancing act

This superordinate theme highlights the many positive ways that participants were impacted by their work while negotiating or balancing the challenging components of therapeutic work. Kearns (1995) described a paradoxical dilemma in which sexual offender clinicians are required to manage their professional relationships with clients while also managing their paradoxical desire to the contrary based on their personal abhorrence to the sexual offending behaviours. This was evidenced across all of the sample leading to the resulting theme, Balancing Act, which was composed of three subordinate themes: Finding somewhere to belong, Pushing professional boundaries and Guardians of the public and the patients. It appeared that participants had shaped their

professional narratives so as to give personal and professional meaning and value to their work thus enhancing their level of resilience.

Finding somewhere to belong. Participants discussed censoring the nature of their role when talking to others outside of work, deeming it necessary to preclude information pertaining to their involvement in sexual offender treatment. This appeared self-protective with the public's negative reaction to this client group leaving individuals feeling challenged and rejected.

That's the bit I find difficult I don't tell anybody other than my family, my son and my daughter know what I do but I wouldn't go and meet somebody and say I work with sex offenders because all you're going to get is a barrage of 'they should be locked up, thrown away' 'they should be on Bas rock' you know 'they should kill them all' well we don't work like that (Marion)

All of the participants had at some time attempted to discuss aspects of their work at home with loved ones, family members, friends or acquaintances. Each participant recalled memories of the resulting upset, confusion or anger. Recollections ranged from disapproving comments and body language to arguments relating to human rights and the legal system. Participants appeared to struggle with the necessity of remaining somewhat silent about their work, 'sometimes I just say em I'm keeping the public safe I'm doing an important job I'm keeping the public safe... and you should be glad that I've done some of this work and said they're not ready to go yet' (Annette). The paradox being that their initial motivation for becoming involved in treating sexual offenders related to the desire to reduce sexual abuse and prevent future victimization in society, 'they don't understand why or how I'm able to do it, I do it so that it doesn't happen again and somebodies got to do it' (Jennifer).

It became apparent throughout the interviews that a dominant method of coping with this was, when at home, to fully detach from their role and assume an identity, which is more akin to society's expectations and norms. Personal and professional lives appeared disconnected to enable the participant to function effectively in both domains.

You've got to deal with it completely separate em I never took it home. I think anyone that does would struggle with it to be honest with you...you do need the difference you can't do that at the end of the day you would struggle (Sean)

When at work however the importance of perceiving a connection to a united collection of professionals appeared pivotal and participants spent a considerable amount of time discussing the rewarding nature of delivering treatment in a group format with co-facilitators 'the team that's very essential, it's real, it's very supportive close team that

we've got em and I don't think we could do the job without that' (Lorraine). Participants spoke about their involvement in the group work programme as being part of a structure that connected to a larger matrix of sexual offender work, 'it's a world of research, there's varying quality but there's always people doing things and talking about things you know so I feel like you can always learn more' (Annette). Rather than viewing themselves as a potentially stigmatized minority, this identification with a niche group of professionals created a sense of belonging to a prestigious professional specialization.

It's quite a challenging patient group, it's quite a patient group that not a lot of people are keen on working with... they picked quite experienced people with quite high eh eh what's the word, positive reputation... to put into the programme we were all senior staff nurses or more senior eh and we all had positive reputations (Richard)

Participants spoke about the consequent feelings of accomplishment from belonging to such a professional group.

I don't know what the right word for me would be but yea kinda I suppose the pride in the work that you do em because you're helping society in in terms of reducing the rates of offending and being able to do something together to help (Jennifer)

Colleagues were found to provide emotional support through normalising and depersonalizing accusations from clients as well as validating individual's reactions to clients and sessions, 'having the other people to look around the room and say 'was it just me that felt that' (Claire). Participants spoke about the reassurance felt, 'the support you get, I like that feeling of not being in it on my own' (Annette) and feeling safety in numbers as Jennifer noted:

Your co-facilitator kind of is watching out for these kind of things... the co-facilitator would come in and kind of save you and yea help you out so it's about working together (Jennifer)

Sharing and comparing their experiences at work seemed to strengthen their position in the team and consequently reduced feelings of detachment and vulnerability.

If you see one of your colleagues just looking stressed out you know you're 'like come on lets go outside and talk for five minutes or lets go for a coffee or what's the matter' we just kind of look out for each other (Lorraine)

In contrast to participants' experiences outwith work then, an ethos of openness had been established in the teams allowing each member to openly share experiences and request support. Steven spoke about feeling able to freely express his frustrations after the group 'team members just allowing me to rant and rave, post group we could say anything, and we were really quite supportive of each other' (Steven). Discussing sessions and client reactions allowed participants to explore and settle emotional responses more easily and reduce rumination in between sessions. The following quote from Lorraine highlights that reciprocity and shared experience is fundamental to effective support:

Just the honesty, if you are struggling with something just you know say to one of your colleagues, 'oh this is absolutely doing my head in and I really can't quite get my head around it' and just kind of talking that through cause invariably the next week they'll do the same with you (Lorraine)

The public's stigmatization of sexual offenders is seldom evidenced towards other offending groups and it would appear that working with those that society has ostracized leaves therapists in a somewhat ostracized position also. Working closely with a socially stigmatized group can leave therapists in a counter-attitudinal position, which serves to increase their vulnerability to being stigmatized by association (Lea, Auburn & Kibblewhite, 1999). This may help in our understanding of why these clinicians involved in sex offender treatment appeared to highly value belonging to a group that shares the same beliefs and experiences, and how this may be crucial to maintaining a positive self image and reducing feelings of isolation and vulnerability. The following extract from Steven perhaps illustrates just how important the cohesiveness of the treatment team is as he made the decision to exit the program following the decision to leave by one of his co-facilitators; 'Probably because of the people I was working with and I think I think once the decision was made by one person to leave all of a sudden it became easy for the other three' (Steven).

Pushing professional boundaries. This constituent theme relates to the elevation of participants to new positions of professional confidence in their ability to manage challenging emotional reactions and cope with a difficult client group. Participants spoke about allowing themselves to push beyond professional boundaries by becoming involved in the group.

There is a stigma about sex offending and sex offenders... I allowed myself to push the boundary and worked out it wasn't as horrific as I thought whereas if I hadn't allowed myself to push the boundaries...I might still be in that kind of percentage of population who say no you and have some kind of stigma (Claire)

For Claire, while initially reticent and unwilling to become involved in this type of work, her decision to become a facilitator enabled her to move through her fears and beyond societal stigma to a more informed confident position. Similarly Marion had come to a place in her life where she was questioning her future and purpose. Despite her fears of group work her decision to begin working with sex offenders allowed her to change the direction of her life and prove to herself that she was capable of taking on and growing from challenges:

I thought to myself am I going to do this till I retire. I need to challenge myself... I was terrified, I was really scared because I'd had negative experiences of the group work but I thought well if you want to grow as a person you've got to take on these challenges (Marion)

Through their work the participants expressed feelings of pride and confidence in their developed ability to work with high-risk sex offenders and manage the challenges that this population poses, 'I'm probably more confident, it's so rewarding, it's very challenging and very draining sometimes but it's very rewarding' (Lorraine). As concerns about confidence were overcome it appeared that participants viewed treatment more realistically and were able to depersonalize clients' failures and set backs as the complexity of offenders' difficulties became clearer.

I think at first I expected everyone to be cured and great and wonderful but now I realise that there's actually small steps within that which do have a big impact. (Louise)

It became apparent throughout the interviews that while professional challenges and development may have initially enticed some participants' entrance into working with this client group, the clients' development and the belief that change can be affected kept participants motivated to stay involved.

You can see the change in them because for a lot of the men when they come to group that's their only time during the week when somebody wants to give them the time of day... seeing that change is rewarding in itself cause you feel like you've done something to help there not be any more victims (Jennifer).

Guardians of the public and the patients. Participants' viewed the 'offenders offences and offending behaviour as being part of the person' (Richard) as opposed to the entirety of a person and spoke about becoming protectors of the clients as well as protectors of society. The participants spoke extensively about separating the offence from the individual

offender and this compartmentalization or 'splitting off' of the offence appeared to facilitate participants' ability to adopt a compassionate approach.

Cause they're people, there's a huge amount to them apart from their sexual offending em like I said earlier there's all the circumstances em that got them to the point that they committed their sexual offences em the way that they've been treated by other people their sort of thought processes their em attachment I mean there's a massive amount of different things that's going in to get them to that point em and it's kind of treating them as persons not sex offenders cause that's what they are (Lorraine)

Seven of the nine participants discussed being motivated to continue this work in order to protect and support these patients.

You see the damage, and you see that generally they could have gone one way or the other, either way they would have been needing some help (Annette)

While participants did not condone the offences, they chose to view this as only one aspect of the individual and spoke about patients in a paternalistic fashion demonstrating concern for them during their time in the group but also afterwards when returning to the community, 'I wonder about what happens after they leave, patients leave here, and how they're managed in the community... you do wonder about how are people ever going to get a chance to demonstrate that they can change' (Louise). This empathetic stance provided participants with the therapeutic approach necessary to work effectively with these clients.

Well my view is that these guys are worth working with you know that not everybody is a lost cause... everybody's got redeeming features and a lot of these guys have just lost their way. They're not evil nasty people as they're portrayed (Marion)

All of the participants spoke about their belief in acting as a barrier between the patient and potential victims. Protecting the community by working with clients to reduce the number of victims was a driving force and participants believed that the group program was the most effective way of reducing the risk posed to the public, 'I was very much, I believe that what we were doing would make a difference, I very much believed that we could reduce reduce the likelihood or someone reoffending' (Sean). Holding on to this focus also helped to continue delivering high quality treatment even when the reality of a client's offence became almost too much to face as Lorraine discussed:

I saw his file and I read through you know looking at the images that the description of the images that he's been viewing em basically it was slim blue eyed boys and I've got a grandson that age group and that's I sat at my desk and cried and thought

I can't work with this guy and I thought the best thing I can do for my grandson is to work with this guy you know to try and reduce the chances of this ever happening to someone ever again (Lorraine)

One participant came to doubt the efficacy of the group programme and consequently struggled with continuing as a treatment provider, 'sometimes you just felt they don't get it this is just a waste of time and I'm still sorta ambivalent about its usefulness... are we spoon feeding them to say the right things to move on?'

Superordinate theme 2: Managing dysfunction

Throughout the interviews participants emphasised the positive impact of their role however they also recognised that delivering treatment to sexual offenders presents therapists with many challenges. This superordinate theme was comprised of three subordinate themes relating to the challenging impact of this work: What's happening to me, The consummate professional and Frustrations of a complex population.

What's happening to me. In this first subordinate theme many of the participants spoke about shifts in beliefs, expectations and assumptions resulting from their involvement in delivering group treatment to sex offenders. Shifts in patterns of thinking appeared to occur along the dimensions of trust revealing new suspicions of others and an increased sense of vulnerability. Participants spoke about increasingly viewing children as victims and starting to interpret potentially innocent events as sinister.

I was at my local supermarket and there's a smashing guy that works there about the same age as me and he's chatting away and then I goes away gets my shopping and I looks back and there's a gran comes in with her a wee six year old girl and she runs up and gives this guy a hug and he's twirling her about and I'm thinking 'God that shouldnea be happening' I was starting to see things in innocent things and I was starting to see the black (Steven)

One participant discussed being more hypervigilant regarding having people baby-sit or care for his children. Participants felt that overall their level of awareness had been altered and was now more sensitive and alert for inappropriate behaviours. They discussed being quicker to ask questions of people and shared experiences of challenging others motives.

I kind of found my myself becoming quite suspicious of people quite quickly... it was summer time and I was walking past and there was there was couple of wee boys playing on a tree...as I was walking past there was two maybe late teens em man young men were walking past the boys and I found myself keeping on turning back to make sure they'd kept walking and to make sure the wee boys were fine em whereas before that wouldn't have even been on my radar (Jennifer)

Similarly these cognitive shifts intruded into a number of participants dreams resulting in nightmares of committing sexual offences themselves.

I can remember dreaming and it was one of the guys index offence... and then you got to the bit where everyone says who done it and everyone's pointing their finger at me and I woke up in a cold sweat... Did that happen 'oh Christ'... a couple of nights later I something similar where I was at a conference or something and I'd sexually assaulted somebody and I thought what the hell's happening to me' (Steven)

Across this sample these cognitive shifts appeared to be most evident at the start of someones experience of working with sexual offenders and then again after a number of years working with this population.

Participants further spoke about the feeling of being 'in a bubble' where they did not realise that their thoughts had become distorted until they spoke to people outside of work; 'We're all in the bubble we don't realize we're in it you know, we've a skewed view of the world...I don't think you always realize that you're skewed' (Annette). The participants identified that their experiences at work had increased the extent to which they questioned their own view of themselves. The increase in self-questioning was most prominent in one participant who spoke about his growing concerns and questions surrounding what made sexual offenders so different to him as a male with sexual interests. At times this raised alarming questions in his mind about his own self with questions of 'am I sex offender', resulting in feelings of shame. Richard's account illustrated the potential impact of this work on therapists' fundamental core beliefs relating to personal identity and the development of distorted and irrational thoughts. Being unaware of whether other treatment providers had experienced similar cognitions Richard felt unable to disclose his feelings to his team for fear of their interpretation.

The other eh thing was the realization to me...that sexual offenders aren't any different to non-offending men...I didna want to tell anybody you know they might think I'm a bit weird...Or maybe it's not because I'm good maybe it's just because I think like that... you worried about whether there was something else going on (Richard)

The consummate professional. Participants further spoke about how working with this client group led to questions about what it means to be a professional. Some of the participants felt that their backgrounds had instilled the belief that to be professional meant suppressing their own emotional responses, 'I left thinking okay no matter what they throw at me I must smile and take it cause if I don't I'm not being professional' (Claire).

Participants discussed using psychological strategies and approaches to manage their emotional responses, 'I kind of have this problem solving approach and to a degree used to try and see the patient kind of like third party you know and I felt nothing towards them' (Claire). In particular emotional detachment was employed whereby participants' detached themselves from their emotional responses to the work as Sean stated, 'You've got to deal with it completely separate... it's a job it's a task...it was purely I've got a job to do' (Sean). This strategy appeared helpful in minimising the impact of intrusive cognitions and enabled facilitators to maintain a professional demeanor however it may have potentially reduced the extent to which facilitators were aware of and reflecting on the impact of their work.

Many participants noted the impact their involvement in sex offender treatment programmes had on their professional lives with other colleagues as well. Participants spoke about interacting with colleagues who did not always appreciate the work that was carried out with offenders believing that 'the group option was the soft option for sex offenders' (Steven). Claire at times was left feeling that other members of the team viewed her as naïve when she tried to speak up on behalf of the patient, 'that feeling that other people are looking at you as if you're maybe a bit soft or a bit daft or you've been a bit duped by the patient ... I'm not naive, I'm not daft, I'm not stupid' (Claire). Some participants also spoke about the alienation and hostility they encountered from other mental health professionals in other fields who appeared to perceive that individuals who work with sexual offenders advocate sexual abuse or show little compassion for victims. Participants felt that if they were to focus on the victim issues they would render themselves ineffective as a treatment provider. In many of the interviews, as illustrated below with Marion's quote, there appeared to be a need to minimize the negative emotions experienced.

We talk a lot in the team about what these guys do to victims...I know all the victim issues but I don't internalize them because I can't internalize them because if I then went into group to work with perpetrators I'd disable myself completely thinking about what they had done to victims ...I've got the best job in the world, I love the group work, my job doesn't affect me at all I mean I'm able to, I don't go home and think about it (Marion)

Participants also spoke about how their feelings towards their work evolved and changed over time as with experience came emotional distance and normalising of offences. Louise illustrated this stating that her job was to provide treatment to men whose 'job' it had been to victimise women and therefore did not feel impacted by what she heard:

They've done things that are horrific that's why they're here so it's kind of the disclaimer that comes with coming to work...it's like okay yea that's his job to that, that's why he's here...my job is to help them explore that and to learn the skills to to move on (Louise).

Participants appeared to feel that to continue to respond emotionally to clients' offence accounts would be ineffective and had become somewhat desensitized and hardened to abuse, 'it seems a bit daft after awhile to keep being shocked when you meet someone... who's em a prolific sex offender and likes children' (Louise).

Working with a complex population. A number of characteristics relating to this client group were raised as challenging and frustrating. In particular, offenders' cognitive distortions (denial, minimization, deception), manipulative or disruptive behaviour, low motivation and lack of victim empathy alongside the contagiousness of clients' negative attitudes and the collusive nature that could evolve in groups.

He just could not tell the truth and he was also aligning himself with other people in the group and eh it was just going to be disruptive cause what we noticed was he aligned himself to one person and when it came to the challenging that person wouldn't challenge anything that he had said, very manipulative (Marion)

The participants found assisting the clients in empathising with the victims very emotionally challenging, with clients often resisting or unable to empathise with the victim:

What we found with offenders is that they can generally get general empathy, but empathy for the victim is a wee bit difficult...they didn't get it...when you're in the room and someone's playing the victim, you're empathizing with the victim, and they're not. So you're sort've taking on all this grief, and all this...and because you're doing that and they're not doing that... and you're saying 'why don't you fucking get it' you know? (Steven)

The modularised nature of the group appeared to create a protective distance between information communicated by patients and the emotional experience of the therapist, 'you're not, you're over satiated with lots of them whereas each one is a little diluted' (Annette). Participants identified that emotional responses were milder in intensity with the group format appearing to reduce the impact of the work. Participants' focus on following the manual and achieving session goals restricted the depth of some of the work thus lessening their exposure to potentially distressing details.

In the group you haven't really got time to do all that...you don't have the time to go into it in as much depth... You're very sort of goal driven you know exactly what's what's happening (Lorraine)

In this study it would seem that the structure afforded by the manual provided a protective barrier. The sense communicated by participants was that forewarned is

forearmed and they felt able to develop strategies in advance by planning sessions so as to be prepared for clients' reactions to challenges to certain beliefs.

You can prepare for each one what you're doing and what you're doing before hand and see if there are going to be any major pitfalls in what you're doing or difficulties and get that set you know (Sean)

The notion that forewarning was necessary perhaps alluding to the participants' apprehension about managing and containing both the clients and their own emotional responses during sessions.

Discussion

The purpose of the present study was to provide an exploratory investigation into the experiences of therapists involved in delivering group treatment to sexual offenders. It is becoming apparent that while the risk of exposure to distressing materials is high for sexual offender therapists the risk of traumatic responding is not (Clarke, 2011) and an understanding of the factors involved may help to elucidate the variable patterns of responding across treatment providers. Some of the experiences reported in the current study were similar to those reported in previous studies (the importance of collegial support, the experience of intrusive cognitions, managing challenging characteristics of sexual offenders and the perception of being involved in protecting the public) but some were not (the prestige felt from belonging to a niche profession, the pride of pushing professional boundaries and the perception of protecting the patient and managing professional challenges) offering further insight into the possible types of experiences encountered. The use of IPA allowed an exploration of individual experiences unencumbered by constructs or objective measures related to similar but distinct fields of research and highlighted the rewarding aspects of this profession as well as the more challenging features.

While this study found elements pertaining to the negative impact of therapeutically working with this client group, evidence of vicarious trauma symptoms, was not predominant within the majority of the interviews. Participants did discuss some changes in cognition commonly associated with vicarious traumatisation (McCann & Pearlman, 1990) including a heightened suspicion of others behaviour and a greater awareness of safety and security (Farrenkopf, 1992; Adams & Riggs, 2008; Ennis & Home, 2003; Kadambi & Tmscott, 2003; Moulden & Firestone, 2007; Way et al., 2004) however, these identifiers of vicarious traumatisation were not viewed as problematic, and were either experienced in such diluted amounts as to limit the effect on therapists' psychological health or else the interviewees had collectively developed a resilience to the

experiences and materials involved in their work. Each participant identified positive and negative effects of being involved in this role. None of the therapists felt that their psychological well being had been compromised suggesting that they were able to adapt and cope with the challenges posed by this work and for most the positive effects of their work outweighed the negative elements. Participants reported an increased sense of accomplishment, pride and confidence through their involvement in the sexual offender treatment and perceived a deeper understanding of themselves and their capabilities as well as a sense of professional development and growth. These findings support the work of Kadambi and Truscott (2006) and other studies, which have reported similar positive themes such as a sense of reward and achievement in facilitating change and wellness, a sense of meaning and purpose, and a belief in the efficacy of treatment and consequent protection of the community (Farrenkopf, 1992; Jackson et al., 1997; Mitchell & Elvik, 1995).

The results clearly demonstrated the pivotal nature of an individual's peer support network and its role in increasing resilience to the risk of psychological distress. Receiving and providing support is a characteristic of resilience and vital in enhancing the positive impact of this work (White, 2008). Coping styles which involved normalising, depersonalising, sharing and comparing experiences, compartmentalising and detaching appeared to protect the participants from negative psychological outcomes (Clarke, 2011; Roger & Hudson, 1995). Appropriate perspective taking by the participants in this study facilitated the formation of mental representations which separated the offence from the offender and allowed participants to experience enhanced levels of enjoyment (Clarke, 2004) and empathy during their work. Conflict with colleagues not involved in providing treatment, doubts as to the efficacy of the treatment and changes within teams were found to increase the risk of negative psychological outcomes such as resignation from the post. In addition some of the depersonalising strategies such as viewing patients as third parties and an over adherence to the manual may have reduced the extent to which therapists were aware of and reflecting on their emotional responses and may have been a hindrance to the therapeutic relationship (Marshall & Marshall, 2009; Drapeau, 2005; Drapeau, Körner, Brunet & Granger, 2004). The majority of participants appeared to have ascribed considerable meaning to their role so that the challenging aspects of treatment were perceived as worthy of investing in and overcoming. Meaning is a central component of resilience (Johnston & Paton, 2003) with accordance such as this between therapist's values, attitudes and behaviours and job requirement leading to increase likelihood of positive outcome. The findings from this study then are in agreement with the burgeoning literature pertaining to the notion that therapists' responses to sexual offender treatment is variable and the result of a complex interplay of a number of different factors.

A limitation of this study relates to the method of analysis selected which is by its nature based upon the researcher's interpretation of participants' accounts. The analysis therefore will invariably reflect personal biases and as such different conclusions may be drawn should those biases be absent in another researcher. Additionally each participant was only subject to one interview providing only a 'snap shot' of their experience. Given the personal nature of this subject matter and the ethos that it is unprofessional to acknowledge negative reactions which can exist in forensic settings some of the participants may have been inhibited and therefore not been fully open about the impact of their work on their life. While the small sample size does not permit generalisability, the identification of pertinent psychological issues and strategies may be transferable to other treatment providers and assist in the clinical relevance of these results. The use of clarity, and the extraction of themes from within and across interviews permits some uniformity and confidence in the interpretation. Future studies that utilise longitudinal methods would be helpful in corroborating our findings but also in discovering additional themes over time.

Perhaps due to the public's condemnation and stigmatization of sexual offenders the prevailing view has established itself as one, which up until recently, unquestionably accepted the detrimental effects on therapists well being (Ryan & Lane, 1991) resulting in an almost exclusive focus on the nature and extent of psychological distress (Clarke, 2011). The consequence of adopting this stance was that distress came to be viewed as inevitable which is not the case for 75-96% of treatment providers who report that delivering sexual offender treatment is one of the most rewarding and satisfying activities of their career (Edmunds, 1997; Ellerby, 1998; Hatcher & Noakes, 2010; Kadambi, 2000; Kadambi & Truscott, 2006; Turner, 1992). Both positive and negative impacts arose from this data highlighting that while deleterious and challenging effects are apparent, individuals benefit personally and professionally from working in this field. Research suggests that therapists negatively impacted by their work are at higher risk of making misdiagnosis, clinical error and poor treatment planning than those not affected (Munroe, 1999; Pearlman & Saakvitne, 1995; Williams & Sommer, 1995; Hesse, 2002). The results of this study may assist in the identification of issues early on so that support can be provided and reductions in competency, days of absence and poorer team functioning avoided. Developing a clearer appreciation of the challenging and rewarding factors involved when working in this field may assist individuals and organisations in ensuring that the rewards are maximised and the challenges supported and reduced.

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Chapter 4. Methodological considerations extended

Quantitative vs. Qualitative Debate

Numerous viewpoints and methodological paradigms can be adopted when conducting psychological research. Qualitative research moves away from the traditional scientific methods of quantitative approaches instead using a more subjective, idiographic position. Qualitative research is then more concerned with the study of subjective experiences by exploring text and meaning as opposed to more traditional cause and effect paradigms (Langdridge, 2004b, 2004d). A more idiosyncratic focus was developed from the belief that psychology should attend to the individual postulating that each person possesses their own unique subjective experiences as opposed to reaching for generalisable commonalities (Ashworth, 2003). With the focus on the individual qualitative research approaches also have the potential to uncover phenomena previously overlooked by scientific methodologies. However as alluded to in Chapter 3, given that the focus with this form of research is the individual a noteworthy criticism relates to the fact that traditional methods of validity and reliability testing are not applicable and equally the ability to generalise from results and replicate explorations is limited (Langdridge, 2004d).

Phenomenology

Phenomenology arose from the philosophical viewpoint of intentionality which postulated that an individual's mind is always of something and is not restricted to an individual's own private self (Langdridge, 2004c, p.274). With this viewpoint phenomenology asserts that each individual's mind is connected to the larger outside world and as such phenomenologists are interested in exploring the experience of consciousness and its connection to the outside world (Langdridge, 2004d). In practicing phenomenological research, intentionality is proposed to be achieved in one of two ways depending on whether Idealism or Realism is followed. Idealists' propose that reality is that which is constructed by an individual's mind, whereas realists' believe that the world is as it is and as such an individual can only know their mind by knowing what there is in the world. Langdridge (2004d, p. 277) however posited that phenomenology should be perceived as moving beyond idealism and realism and instead be focused on accessing and understanding an individual's experience. In this way phenomenologists can be said to be truly focused on the intentionality of a phenomenon.

The founder of Phenomenology, Edmund Husserl sought to uncover the 'real truth' underlying an individual's account by taking their subjective experience as reality. Husserlian phenomenology used the theory of 'The Reduction' which requires the

researcher to set aside any of their own preconceived ideas or hypotheses so as to effectively bracket their own ideas and notions and experience the phenomenon in its unbiased true state (Finlay, 2008). Such bracketing extended to a researcher's scientific background and knowledge of the investigated area, their own personal thoughts and feelings about a phenomenon as well as their philosophical/spiritual beliefs. Husserl further imposed 'Radical Autonomy', which stipulated that individuals are independent of their environmental surroundings and influences such that societal, cultural and political issues do not influence an individual's free agency (Lopez & Willis, 2004). As a researcher then the aim is to achieve transcendental subjectivity by separating oneself from previous knowledge so as to achieve knowledge independent of experience.

The separation of one's previous experiences and knowledge was viewed as problematic by fellow German philosopher Heidegger who believed that a researcher would inevitably bring with them their past experiences and knowledge of the area of study and that this should be viewed as enriching the study as opposed to impairing it (Lopez & Willis, 2004). Phenomenology was then split into a second branch called hermeneutics which was developed to surpass the descriptive account of an individual's experience and strive for uncovering the meaning attributed by the individual whether consciously recognised or not (Lopez & Willis, 2004). For hermeneutics the focus was on interpretation and understanding the lived experience in full awareness of our own previous and present day selves and all the thoughts, knowledge and understanding that that implies (Finlay, 2008). As opposed to Husserlian phenomenology, which attempted to bracket the researcher's offerings, hermeneutics stipulated that phenomenologists remain alert and transparent with regard to their biases (Gadamer, 1975). Heidegger also proposed, 'Situated Freedom', which postulated that individuals are free to make their own choices within the confines of their current life situation. In this way the forming of decisions involves uncertainty and unknown consequences, which imposes on an individual's experience, and the meaning they derive. Heidegger's interpretative phenomenology therefore was focused on exploring how social and historical influences impact the meaning that individuals derive from experiences. Without the necessity of bracketing, hermeneutics is also focused on highlighting the inter-connectedness of the researcher and the participant during the interview. Heidegger believed that the meaning postulated by the researcher is an articulation of the blended meaning experienced by the researcher and the participant throughout the interview (Lopez & Willis 2004).

The study included in this thesis was analysed using hermeneutic phenomenology which is generally employed according to the Duquesne school created by Amedeo Gioigi and latterly the Interpretative Phenomenological Analysis (IPA) developed by Jonathan

Smith. The next section is a detailed review of IPA and its similarities/differences to other qualitative methodologies.

Interpretative Phenomenological Analysis

“IPA does not make any claims about the external world. It does not ask whether participant’s accounts of what happened to them are true or false or to what extent theory perception of an event corresponds to the external reality” (Willig, 2001, p. 67).

IPA is primarily focused on revealing how people view, make meaning of and experience phenomenon. This is achieved by identifying the occurrence of recurrent themes embedded within an individual’s phenomenological account of their experience in their own subjective experience (Smith, Jarman, & Osborn, 1999). Hypotheses are not set nor tested with the participant viewed as the expert in their experience. During both the interview and analytic process it is acknowledged that the researcher will exert an inevitable and unavoidable influence over the process and outcome and uses this to fulfill the interpretative component of the procedure. This allows a shift away from scientific realism into a more contextualist view of reality (Madill, Jordan, & Shirley, 2000). A reflective stance from the researcher is required with IPA acknowledging the influence of the researcher in shaping the interpretations.

IPA, Thematic Analysis, Discourse Analysis and Grounded Theory

Up to 2006 thematic analysis was viewed as an umbrella term, which situated all qualitative analysis underneath it. Thematic analysis however has come to be recognised as a distinct form of qualitative analysis (Braun & Clarke., 2006). IPA is distinguishable from thematic analysis in its phenomenological epistemology and structured method of application (Braun & Clarke, 2006). Discourse analysis is based in realist epistemology and is separated into discursive psychology and Foucauldian discourse analysis with the former focusing on how people use words and language as actions during discourse (Langdridge, 2004a) and the latter focusing on how words can be used to construct the social world (Langdridge, 2004a). Grounded theory was focused on social processes and is rooted in a social science ontological perspective. Being based in a sociological school of thought grounded theory has been used and applied to social science. Debate exists as to the similarity of grounded theory and IPA with Willig (2001) arguing that they are quite similar but individuals such as Landridge (2004c) postulating that IPA has greater similarities to thematic analysis. Despite some similarities grounded theory’s focus remains on describing the social processes in the social sciences whereas the focus in IPA

is to describe individual psychological experiences and phenomena in psychological sciences.

Criticisms of IPA

Criticisms of IPA have focused on the 'conceptual and practical limitations: the role of language, the suitability of accounts and explanation versus description and the fact that is IPA really phenomenological' (Willig, 2001, p. 63). Willig's concern focused around the danger that an over emphasis on language can result in an account of how someone describes a certain experience without providing information about how an individual actually experienced the event. Willig further expressed concerns over relying on an individual's ability to articulate their thoughts, feelings and resultant meaning of an experience (2001). Willig and Langdridge have also both questioned whether IPA can be considered truly phenomenological given that IPA places an emphasis on cognition, which can be viewed to contradict phenomenology's basis of intentionality 'genuinely phenomenological research should not study people's cognitions instead it should aim to understand the lived experience' (Langdridge, 2004d, p. 65). Criticisms from more quantitative researchers relates to the fact that IPA is concerned with reporting on an individual's experience as opposed to explaining the phenomenon. In doing so IPA is then focused on an individual's perceptions and how they have made sense of an experience and not interested per se in investigating 'why' they have experienced something in a particular way or whether other individuals subjective accounts and attributed meanings differ (Willig, 2001).

Concerns regarding the retrospective nature of IPA have also been levied against this form of analysis. Giorgi and Giorgi (2003) raised two potential issues that may arise from solely using self-reported retrospective accounts and they are the possibility of error and deceit. Error is not viewed as problematic for IPA however as the researcher is interested in an individual's subjective account as opposed to the objective account. Whether an individual remembers an event in a factual accurate way therefore is not of primary importance. The focus rests on how an individual remembers experiencing the phenomenon. In this way errors can be said not to occur in a way that is problematic for the phenomenological researcher. Deceit may be more troublesome however the use of detailed and longer interviews can effectively combat this by detecting interviews, which sound scripted or inconsistent. In addition when using IPA a specific focus is not applied to the interview, which is allowed to evolve in a more organic fashion. This can make it harder to deceive an interviewer as a specific hypothesis has not been proposed for testing "no specific hypothesis or theory is being advanced, so it is difficult to know why

deceit would motivate the participant unless to cover up personal failures or embarrassments' (p.47). Giorgi and Giorgi (2003) also make the point that deception is apparent for both quantitative and qualitative researchers but may be more easily applied and harder to identify when using questionnaire style measures.

Rationale for Using IPA

IPA utilises small sample sizes to enable a focus on the idiographic nature of experience. Sampling is purposeful and homogeneous so as to obtain a self-selected (expert) sample that can elucidate a specific phenomenon at an idiographic level. By using a homogeneous group questions can be raised for further investigation. IPA then is a form of analysis that allows us to determine something about a group of people as opposed to groups in general. Transcription and analysis is rigorous and not wholly prescriptive enabling the analyst to ensure the individual is maintained throughout with consideration given to an individual's experiences, thoughts, intentionality and sense of agency. The analysis is inductive but during the interpretative processes makes use of deductive systems providing a balance between the unique individual and the group but maintaining the focus on the individual. The use of unstructured interviews in IPA facilitates freedom of expression often restricted by questionnaire-based measures. In this way previously unknown elements of a phenomenon may come to light and be explored (Cohen, Cimboric, Armeli, & Hettler, 1998). IPA also affords the opportunity to explore the process involved in people's experiences and meaning making. IPA has not routinely been used to explore the impact of delivering treatment to sexual offenders, as this is a relatively young area of research. This approach then provided the opportunity of exploring an area with few preconceived hypotheses and enabled the discovery of new elements of this phenomenon (Mayers, Naples & Nilsen, 2005).

Owning One's Own Perspective

Given the reflective component inherent in IPA researchers are afforded the opportunity to discuss any personal connection they may have with the subject area or participants. This can add to the transparency of the analysis by clearly and honestly situating the researcher for the reader. In this way readers can be mindful of and alert to any potential influence of the researcher in the interpretative of the interviews and formulate their own opinion as to whether the researcher has been influenced by their background. As the researcher in this instance I can say that I had not had any personal or professional direct contact with sexual offenders or sexual offender treatment providers prior to commencing this piece of research.

Analysis

The process engaged in when analysing the transcripts has been detailed in Chapter 3 and will therefore not be repeated here. A number of additional considerations relating to stage 2, 3 and 4 of the analysis process (see Chapter 3) were not suitable to include in the article and as such are included below.

Stage 2 – Initial notes

The exploratory coding which takes place in stages 2 and 3 is the most time intensive aspect of the analytic process. Stage 2 involves the word for word, line by line analysis, recording notes of interest in the right hand margin. The comments and reflections placed in the right hand column relate to three main areas of interpretations as stipulated by Flowers (2006). During this stage descriptive, linguistic and conceptual/interpretative notes were made. Descriptive notes commented on the content of the transcript, linguistic notes referred to the type of language used and conceptual notes related to the interpretation of the transcript. The conceptual/interpretative coding is the deepest layer of analysis and moves the reader beyond a mere description of the text to a level where the underlying meaning of phrases and accounts are proposed. This starts the interpretative engagement with the text, participants, researcher and analytic process (Flowers, 2006). Table 1. Illustrates this process.

Table 6. Stage 2 line-by-line analysis

Emergent themes	Transcript excerpt	Initial notes
	Researcher: So that therapeutic relationship does is that impacted?	
	Participant: They're people, there's a huge amount to them apart from their sexual offending em like I said earlier there's all the circumstances em that got them to the point that they committed their sexual offences em the way that they've been treated by other people their sort of thought processes their em attachment I mean there's a massive amount of different things that's going in to get them to that point em and it's kind of treating them as persons not sex offenders cause that's what they are	Describes the complexity of the individuals being treated. <i>"huge", "all", "massive" – emphasis on the bigger picture and the individual being more than their offences.</i> Feeling of inevitability and vulnerability given the offenders background, shared responsibility, desire to protect.

Normal script = descriptive, *Italic script* = linguistic, **Bold script** = interpretive.

Stage 3 – Developing emergent themes

When the line-by-line process was complete the analysis moved on to develop the emergent themes. During stage 3 themes are developed which retain the interpretative essence of the original text. As outlined by Smith and Osborn (2003), exploratory coding involves the use of more psychological terminology and higher levels of abstraction. During this phase the entire transcript is reviewed and text is converted into emergent themes. The initial notes are used to begin developing these emergent themes, which are written into the left hand column. These emergent themes are used to capture the essence of the text. It would not be possible to generate emergent themes for each section of the transcript given the volume of data involved in a recording. This again highlights the role of the researcher as an interpretative element of the analysis. Table 2 below illustrates this process.

Table 7. Stage 3 developing emergent themes

Emergent themes	Transcript excerpt	Initial notes
	Researcher: So that therapeutic relationship does is that impacted?	
People who sexually offend have complex backgrounds.	Participant: They're people, there's a huge amount to them apart from their sexual offending em like I said earlier there's all the circumstances em that got them to the point that they committed their sexual offences em the way that they've been treated by other people their sort of thought processes their em attachment I mean there's a massive amount of different things that's going in to get them to that point em and it's kind of treating them as persons not sex offenders cause that's what they are	Describes the complexity of the individuals being treated.
Emphasis on just how much clients have had to live through.		<i>"huge", "all", "massive" – emphasis on the bigger picture and the individual being more than their offences.</i>
Being a protector of clients.		Feeling of inevitability and vulnerability given the offenders background, shared responsibility, desire to protect.

Normal script = descriptive, *Italic script* = linguistic, **Bold script** = interpretive.

Stage 4 - Searching for connections across emergent themes

When the emergent themes have been identified a list of the themes is compiled to facilitate the search for connections between themes. During this phase the researcher

engages in a process of analysis to make sense of and group the themes into some form of theoretical order. During this process some themes will present as more important than others for the individual and equally some themes will appear to originate from more central themes in a hierarchical manner. At this stage all of the themes are retained so as not to lose any of the data (Langdridge, 2004c).

Once each transcript has been individually analysed and a list of emergent themes has been generated and connections made between themes the final stage of analysis can begin. During this phase a superordinate themes list is created. This is a controversial component of the analysis as it requires the researcher to select the themes to focus on and condense them into a coherent account (Smith & Osborn, 2003). Unlike other forms of analysis the decision as to which themes to retain is not based on statistical prevalence but on issues relating to, “the richness of the particular passages that highlight the themes and how the themes helps illuminate other aspects of the account” (Smith & Osborn, 2003, p. 76). The high prevalence of a theme across transcripts therefore does not necessarily indicate its level of importance (Braun & Clarke, 2006). Equally a theme may be retained if it is only mentioned once or twice in a transcript by one participant. The value of a theme is therefore based on the extent to which it captures an important component for the research question. Braun and Clarke (2006) have argued as to whether reports of prevalence should be a feature of this type of analysis at all.

The issue of prevalence

As the process of analysis continues to identify and condense superordinate themes across the transcripts, some initial themes become subthemes or are merged into high order themes depending on their richness and importance. This process continued during the writing up stage where at times it became evident that some themes were insufficient (e.g. insufficient data to support the theme or there was too much diversity in the data set) and other themes collapsed into each other so that two themes became one. Overall, ‘Finding somewhere to belong’ was present in all nine of the participants transcripts, ‘Guardians of the patients and the public’ was raised by seven participants, ‘The consummate professional’ and ‘Frustrations of a complex population’ by six participants and ‘Pushing personal boundaries’ and ‘What’s happening to me’ by five participants.

Quality control in IPA

A discussion as to the necessity of assessing quality in qualitative research is included in Chapter 3 however it is perhaps worth noting this issue in relation to IPA specifically. IPA has been developed on the belief that it is not possible to fully understand or conceive of our participants’ world due to our own biases and interpretations of their experiences. In this way the validity of IPA can be viewed to rest in the examples and excerpts used to

demonstrate and support the interpretations of the experiences shared by the participants (Flowers & Buston, 2001).

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Appendix I – Systematic review author guidance

Journal of Aggression and Violent Behavior

The information included below has been taken from the information pack supplied for authors submitting to the Journal of Aggression and Violent Behaviour.

Aggression and Violent Behavior, A Review Journal is a multidisciplinary journal that publishes substantive and integrative reviews, as well as summary reports of innovative ongoing clinical research programs on a wide range of topics germane to the field of aggression and violent behavior. Papers encompass a large variety of issues, populations, and domains, including homicide (serial, spree, and mass murder: sexual homicide), sexual deviance and assault (rape, serial rape, child molestation, paraphilias), child and youth violence (firesetting, gang violence, juvenile sexual offending), family violence (child physical and sexual abuse, child neglect, incest, spouse and elder abuse), genetic predispositions, and the physiological basis of aggression.

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Article structure

Subdivision - numbered sections

Divide your article into clearly defined and numbered sections. Subsections should be

numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line.

Introduction

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods

Provide sufficient detail to allow the work to be reproduced. Methods already published should be indicated by a reference: only relevant modifications should be described.

Theory/calculation

A Theory section should extend, not repeat, the background to the article already dealt with in the Introduction and lay the foundation for further work. In contrast, a Calculation section represents a practical development from a theoretical basis.

Results

Results should be clear and concise.

Discussion

This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions

The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. • *Author names and affiliations.* Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author. The title page is to be the first page of the manuscript; the second page is the abstract with key words.

Corresponding author. Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address" (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

A concise (no more than 200 words) and factual abstract is required. This should be on a separate page following the title page and should not contain reference citations.

References

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

References in a special issue

Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue. *Reference management software* This journal has standard templates available in key reference management packages EndNote (<http://www.endnote.com/support/enstyles.asp>) and Reference Manager (<http://refman.com/support/rmstyles.asp>). Using plug-ins to wordprocessing packages, authors only need to select the appropriate journal template when preparing their article and the list of references and citations to these will be formatted according to the journal style which is described below.

Reference style

Text: Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 978-1-4338-0561-5, copies of which may be ordered from <http://books.apa.org/books.cfm?id=4200067> or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK.
List: references should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.
Examples: Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton, R. A. (2010). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51-59. Reference to a book: Strunk, W., Jr., & White, E. B. (2000). *The elements of style*. (4th ed.). New York: Longman, (Chapter 4). Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.
Journal abbreviations source Journal names should be abbreviated according to: List of title word abbreviations: <http://www.issn.org/2-22661-LTWA-online.php>; NLM Catalog (Journals referenced in the NCBI Databases): <http://www.ncbi.nlm.nih.gov/nlmcatalog/journals>; CAS (Chemical Abstracts Service): via <http://www.cas.org/content/references/corejournals>.

Appendix II – Journal article author guidance

The information included below has been taken from the information pack supplied for authors submitting to the Journal of Psychology, Crime and Law.

Psychology, Crime & Law promotes the study and application of psychological approaches to crime, criminal and civil law, and the influence of law on behavior. The content includes the etiology of criminal behavior and studies of different offender groups; crime detection, for example, interrogation and witness testimony; courtroom studies in areas such as jury behavior, decision making, divorce and custody, and expert testimony; behavior of litigants, lawyers, judges, and court officers, both in and outside the courtroom; issues of offender management including prisons, probation, and rehabilitation initiatives; and studies of public, including the victim, reactions to crime and the legal process. It publishes reviews and brief reports which make a significant contribution to the psychology of law, crime and legal behavior.

Manuscript preparation

1. General guidelines

Manuscripts are accepted in English. British English spelling and punctuation are preferred. Please use single quotation marks, except where 'a quotation is "within" a quotation'. Long quotations of 40 words or more should be indented without quotation marks.

Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Abstracts of 200 words are required for all manuscripts submitted.
Each manuscript should have 5 to 5 keywords .
Section headings should be concise.

Article type (when needed)	RESEARCH ARTICLE bold caps, centred
Title	Bold, first word and proper nouns cap only Centred
Authors	An Author and Another Author (initials closed up if J.B. Smith) centred
Affiliation	<i>aDepartment, University, City, Country; bDepartment, University, City, Country</i> centred
Received dates	(Received 20 July 2011; accepted 17 August 2012) After affiliation, centred

Abstract	Text smaller, indented both sides Centred
Keywords	Keywords: word; another word; lower case except names Position aligned with abstract, same size as abstract
Correspondence details	Given as footnote on page 1* *Corresponding author. Email: xxxxxxxx ranged left, no indent. Postal address not included in footnote. If there is only one author, use *Email: xxxxxxxx
Headings	A. Bold initial cap only B. <i>Bold italic initial cap only</i> C. <i>Italic initial cap only</i> D. <i>Italic initial cap only</i> . Text runs on All ranged left, numbers to be included if supplied, no indent below.
Paragraphs	Indented
Tables	(Table 1) in text. Table 1. Title initial cap only. (ranged left above table) Note: This is a note. (ranged left under table)
Figures	(Figure 1) in text. Figure 1. Caption initial cap only. (ranged left under figure) Note: This is a note. (ranged left under figure)
Permissions statement for third-party figure and table captions	If the rightsholder has supplied text for this purpose, use their text. Otherwise, insert the rightsholder's name within the square brackets: © [Rightsholder]. Reproduced by permission of xxx. Permission to reuse must be obtained from the rightsholder.
Displayed quotations	Indented left and right, smaller font (over 40 words, or when appropriate)
Lists	(1) for numbered lists Bullets if wanted
Equations	Equation (1) in text Centred
Acknowledgements	A heading. Goes before notes, bio notes and refs Text smaller

Appendix III – Descriptors of attachment measures used by included studies

The Childhood Attachment Questionnaire

The Childhood Attachment Questionnaire (CAQ) (Hazan & Shaver, 1987) is composed of three paragraphs that relate to Ainsworth, Blehar, Waters, & Wall's (1978) three major childhood attachment styles (secure, anxious/ambivalent, and avoidant). Individuals are asked to rate how well each descriptor relates to their mother and father's attitudes, feelings and behaviours towards them when they were growing up on a 7-point Likert scale. The questionnaire is completed for maternal and paternal attachment relationships separately. Moderate to high test-retest reliability has previously been demonstrated in a sample of incarcerated sexual offenders (Smallbone & Dadds, 1998).

The Parental Bonding Instrument

The Parental Bonding Instrument (PBI) (Parker, Tupling & Brown, 1979) is a 25 item measure designed to explore an individual's recollections of their parents' bonding attitudes and behaviours prior to the age of 16. The PBI is completed separately for each parent or parental figure. Each item is rated on a four-point Likert scale and scores relate to two subscales: 'Care' and 'Overprotection and Control'. Four parenting styles can be identified depending on the combination of 'Care' and 'Control' scores: optimal parenting (high care, low control); affectionate constraint (high care, high control); affectionless control (low care, high control); and neglectful parenting (low care, low control). Wilhelm, Niven, Parker and Hadzi-Pavlovic (2005) have reported good reliability and validity of the PBI across different populations and over extended time periods.

The Adult Attachment Scale

The Adult Attachment Scale (AAS, Hazan & Shaver, 1987) is used to measure adult romantic attachment styles. This scale contains: a multiple-choice section with three response categories (secure, avoiding, and anxious-ambivalent attachment styles) and a 7-point scale on which the level of secure, avoiding, and anxious-ambivalent attachment can be marked. At 11 weeks apart, the test-retest correlation was .80, indicating that it is a stable measure (Crowell, Fraley, & Shaver, 1999).

The Attachment Style Questionnaire

Developed by Feeney, Noller and Hanrahan (1994) the Adult Style Questionnaire (ASQ) was designed to determine where a person falls on two dimensions: view of self, and view of others. Participants are asked to rate forty questions using a 6-point Likert format. The factors labeled Preoccupation with Relationships and Need for Approval pertain primarily to attitudes of self. The scales labeled Discomfort with Closeness and Relationships as Secondary primarily assess attitudes of others. Another scale, Confidence, relates to both view of others and view of self.

Adult Attachment Interview

The Adult Attachment Interview (AAI, George, Kaplan, & Main, 1985) requires participants to retrospectively reflect on their childhood attachment experiences to assess the likely impact of these experiences on their own development and behaviour. Securely attached adults tend to appear comfortable reflecting on their childhood experiences and present as comfortable with closeness and personal emotions (Main, 1995). Preoccupied adults appear fearful, angry or confused when recalling relationships. Dismissing adults appear to remember little from their childhood and have been shown to only provide limited responses. Adults with an unresolved/disorganised attachment are viewed as still affected by their unresolved trauma or loss (Hesse & Main, 1999).

The Experiences in Close Relationships Scale (ECR)

The ECR (Brennan et al. 1998) is a 36-item adult attachment measure. This measure can be used to assess attachment related anxiety (how insecure vs. secure people are about the availability and responsiveness of romantic partners) and attachment related avoidance (how uncomfortable people are being close to others vs. how secure people are depending on others).

Experiences in Close Relationships Inventory

The Experiences in Close Relationships Inventory (ECRI; Brennan, Clark & Shaver, 1998) is a 36-item assessment with two 18-item subscales (attachment-related anxiety and attachment-related avoidance). Individuals are asked to indicate how well each of 36 items describes their typical feelings in romantic relationships on a 7-point Likert scale ranging from 1 (disagree strongly) to 7 (agree strongly). The avoidance scale items are designed to assess discomfort with interpersonal closeness, dependence, and intimate

self-disclosure. The anxiety scale items measure an individual's fears relating to abandonment and strong desires for intimate contact. The ECRI has established validity with college and adult samples (Brennan et al. 1998; Mikulincer & Shaver 2007). Test-retest coefficients among non-offender samples have been found to be .71 (avoidance) and .68 (anxiety) (Lopez & Gormley, 2002). The attachment-related avoidance and anxiety subscales are continuous dimensions rather than discrete attachment types (Fraley and Waller 1998).

ECRI-State - Experiences in Close Relationships Inventory (ECRI-State)

The ECRI-State measure is identical to the original ECRI, except that the participants were asked about their experiences with a specific intimate partner in the weeks preceding the onset of their sexual offense. Only those offenders who identified being in an intimate partner relationship in the month preceding their onset sexual offense were required to complete the ECRI-State. The reliability and validity of this modified version of the ECRI have not been previously established.

Relationship Scales Questionnaire (RSQ)

The RSQ enables the identification of dimensional scores for the four attachment styles (secure, fearful, preoccupied and dismissing) as well as a two-dimensional score for view of self (anxiety) and view of others (avoidance). This questionnaire is composed of 30 statements about how an individual may be in close relationships. The statements were developed using Shaver's (1987) attachment measure, Bartholomew and Horowitz's (1991) Relationship Questionnaire, and Collins and Read's (1990) Adult Attachment Scale. Internal consistency has been demonstrated to be moderate between scales with alpha values ranging from .41 for secure styles to .70 for dismissing (Griffin & Bartholomew, 1994). The RSQ has also been used with an offending population (Baker & Beech, 2004; Smallbone & Dadds, 1998; Ward, Hudson, & Marshall, 1996).

The Relationship Questionnaire (RQ)

This is a 4-item questionnaire designed to measure adult attachment style (Bartholomew & Horowitz, 1991). The RQ extends Hazan and Shaver's (1987) Three category attachment measure (Hazan & Shaver, 1987) by adding a fourth style - dismissing-avoidant. The RQ is composed of four short paragraphs, which describe the four attachment styles (secure, preoccupied, fearful, and dismissing). Using a 7-point Likert scale individuals indicate

how much each statement is like them. Ratings are used to compute underlying models of self and other attachment dimensions (Griffin & Bartholomew, 1994). The RQ can be used to explore orientations towards close relationships, romantic relationships or specific relationships.

The Experiences in Close Relationships Scale (ECR),

The ECR is a 36-item self-report measure of adult attachment (Brennan et al., 1998). Respondents use a 7-point to rate how well each statement describes their typical feelings in romantic relationships. The results of a factor analysis by Brennan et al. (1998) identified two relatively orthogonal continuous attachment dimensions labeled anxiety (18 items) and avoidance (18 items). Higher scores on the anxiety and avoidant subscales indicate higher levels of attachment anxiety and attachment avoidance, respectively.

The Experiences in Close Relationships Scale-Revised

The Experiences in Close Relationships-Revised (ECR-R) questionnaire (Fraley, Waller & Brennan, 2000) is a revised version of Brennan et al's (1998) Experiences in Close Relationships (ECR) questionnaire. The 36 items in the ECR-R were selected from the same item pool as those from the ECR. The ECR-R measures individuals on two subscales of attachment: avoidance and anxiety. In general avoidant individuals find discomfort with intimacy and seek independence, whereas anxious individuals tend to fear rejection and abandonment.

Appendix IV – Systematic review excluded studies

Table A.1 Excluded studies

1	Albert	2005	Dissertation	PsychInfo
2	Alexander	2003	Book chapter	PsychInfo
3	Alexander & Anderson	1997	Conference paper	PsychInfo
4	Allanson & Astbury	2001	Attachment not primary outcome	PsychInfo
5	Baker	2007	Book review	PsychInfo
6	Baker, Beech & Tyson	2006	Review	Psychology & Behavioural Sciences Collection
7	Baltieri & Andrade	2007	Dissertation	PsychInfo
8	Beech & Mitchell	2005	Review	PsychInfo
9	Bolen	2002	Opinion	CINAHL
10	Burk & Burkhart	2003	Review	PsychInfo
11	Cameron	2007	Review	CINAHL
12	Cohen, Garofalo, Boucher & Seghorn	1971	Opinion	EMBASE
13	Cookie & Bachman	2005	Sexual offenders not primary sample	PsychInfo
14	Craissati	2009	Book chapter	PsychInfo
15	Craissati & Beech	2003	Review	PsychInfo
16	D'Alton, Guilfoyle & Randall	2013	Qualitative	EMBASE
17	Dempster	2007	Dissertation	PsychInfo
18	Drapeau	2006	Attachment not primary outcome	Medline
19	England	1997	Dissertation	PsychInfo
20	Farr	2010	Dissertation	PsychInfo
21	Frost	1984	Dissertation	PsychInfo
22	Gannon, Terriere & Leader	2012	Attachment not primary outcome	PsychInfo
23	Gibeau	1989	Dissertation	PsychInfo
24	Giotakos, Vaidakis, Markianos, Christodoulou & Psychiatriki	2003	Attachment not primary outcome	PsychInfo
25	Giotakos, Vaidakis, Markianos, Spandoni & Christodoulou	2004	Attachment not primary outcome	EMBASE
26	Greenberg, Firestone, Nunes, Bradford & Curry	2005	Attachment not primary outcome	Medline
27	Gunn	2011	Dissertation	PsychInfo
28	Haapasalo & Kankkonen	1997	Attachment not primary outcome	Medline
29	Haymaker	1989	Dissertation	PsychInfo
30	Hudson Allez	2010	Book	PsychInfo
31	Januszewski	1997	Book	PsychInfo
32	Kalichman, Sarwer, Johnson, Ali, Early & Tuten	1994	Sexual offenders not primary sample	PsychInfo
33	Kanter	2000	Dissertation	PsychInfo
34	Kear-Colwell & Sawle	2001	Attachment not primary outcome	PsychInfo
35	Kimball	2004	Dissertation	PsychInfo
36	Krzycki & Grim	2004	Dissertation	PsychInfo
37	Kwako, Noll, Putnam & Trickett	2010	Sexual offenders not primary sample	CINAHL
38	Lang & Langeyin	2006	Attachment not primary outcome	EMBASE
39	Lynn	2010	Dissertation	PsychInfo
40	Hilgarth, Volk, Lange-Joest, Birmelin, Schempp & Diebold	1983	Attachment not primary outcome	Medline
41	Macnab & Lee	1997	Dissertation	PsychInfo

42	Maniglio	2012	Review	EMBASE
43	Markham & Mikail	2004	Book chapter	PsychInfo
44	Markham & Mikail	2004	Case study	PsychInfo
45	Marshall	1993	Theoretical	CINAHL
46	Marshall	2001	Book chapter	PsychInfo
47	Marshall & Marshall	2010	Review	CINAHL
48	Marshall & Mazzucco	1995	Attachment not primary outcome	PsychInfo
49	Marshall & Siegert	1995	Review / theoretical	PsychInfo
50	Marshall, Fernandez, Marshall & Serran	2008	Book chapter	PsychInfo
51	Milner & Webster	2005	Attachment not primary outcome	PsychInfo
52	Miner, Robinson, Knight, Berg, Romine & Netland	2010	Sexual offenders not primary sample	PsychInfo
53	Noonan	2012	Dissertation	PsychInfo
54	Nuckols	2010	Dissertation	PsychInfo
55	Nussbaum, Collins, Cutler, Zimmerman, Ferguson & Jacques	2002	Attachment not primary outcome	PsychInfo
56	Overholster	1986	Dissertation	PsychInfo
57	Bennett	1986	Dissertation	PsychInfo
58	Schachner & Shaver	2004	Sexual offenders not primary sample	PsychInfo
59	Schmidt & Eldridge	1986	Theoretical	PsychInfo
60	Shaw, Lewis, Loeb, Rosado & Rodriguez	2000	Sexual offenders not primary sample	Medline
61	Simon	1997	Dissertation	PsychInfo
62	Smallbone & Dadds	2000	Adolescent sample	EMBASE
63	Smallbone & McCabe	2003	Qualitative paper	PsychInfo
64	Starr	2009	Dissertation	PsychInfo
65	Starzyk & Marshall	2003	Review	EMBASE
66	Stirpe	2003	Dissertation	PsychInfo
67	Theunissen	2005	Theoretical	PsychInfo
68	Thompson	2011	Dissertation	PsychInfo
69	Thomson	1995	Dissertation	PsychInfo
70	Tingle, Barnard, Robbins, Newman & Hutchinson	1986	Attachment not primary outcome	Medline
71	Van Horn	2006	Dissertation	PsychInfo
72	Ward, McCormack & Hudson	2002	Qualitative paper	EMBASE
73	Wood	2007	Dissertation	PsychInfo
74	Wurtele & Durham	2008	Attachment not primary outcome	EMBASE

Appendix V – Systematic review criteria for methodological review

December 2013

Review question: Is there is a relationship between sexually deviant behaviours and attachment style. Secondary review question; is there a difference in attachment styles between types of sexual offending.

Quality criteria

- 1 The study addresses an appropriate and clearly focused question
- 2 The participants are representative of the group being studied
- 3 The study describes how participants were recruited
- 4 A control/comparison group was included.
- 5 Cases and controls were clearly defined and differentiated.
- 6 The same exclusion criteria was used for cases and controls
- 7 The authors used an appropriate method to answer their question
- 8 The statistics used were reported and appropriate E.g. Parametric vs. non-parametric.
- 9 Were the main potential cofounders identified and taken into account in the design and analysis?
- 10 Were the results well reported e.g. effect size, significant vs non-significant results discussed?
- 11 Do the results fit with other available evidence?
- 12 Have the limitations of the study been discussed?

Developed in accordance with SIGN, CASP, NICE and York guidelines for completing systematic reviews with cohort and case control articles.

Operationalisation of quality criteria

1. The study addresses an appropriate and clearly focused question

Well covered	Study presents a comprehensive rationale culminating in a focused research question(s) and clearly stated hypotheses for investigation.
Adequately covered	Study presents a rationale for study however the details of such are less well covered and hypotheses are not clearly stated.
Poorly addressed	Rationale and research questions are vaguely stated providing limited information.
Not addressed	A clearly focused research question was not addressed in this study.
Not reported	No details pertaining to the research question reported.
Not applicable	Research question is not applicable for this study.

2. The participants are representative of the group being studied

Well covered	The patients included in the study were recruited from a representative clinical setting and participants were reasonably representative of the wider clinical population.
Adequately covered	Participants were recruited in a clinical setting but there were probably substantial bias in those approached and/or amongst those who participated.
Poorly addressed	Participants were recruited in a clinical setting but there were clear substantial bias in those approached and/or those participated.
Not addressed	Participants were not recruited in a clinical setting or attempts were not made to be representative of the wider clinical population.
Not reported	Generalisability of study results was not reported
Not applicable	Issues relating to generalisability of the studies results are not applicable.

3. The study describes how participants were recruited

Well covered	The process of recruitment was comprehensively presented including recruitment procedure, total number of participants approached and total included in analysis.
Adequately covered	Details pertaining to the recruitment procedure were presented but information was limited.
Poorly addressed	Minimal information about recruitment procedure provided.
Not addressed	Information about recruitment and sample size was not addressed in this study.
Not reported	Recruitment and sample size not reported.
Not applicable	Details relating to the recruitment process and sample size were not applicable for this study.

4. A control/ comparison group was included.

Well covered	Study included a non-offender control group as well as a non-sex offender comparison group.
Adequately covered	Study included a non-offender control group or a non-sex offender comparison group.
Poorly addressed	No control or comparison group was used. All analysis was carried out on data from individuals who had sexually offended.
Not addressed	Information about control and/or comparison groups was not addressed in this study.
Not reported	Control and comparison group details not reported.
Not applicable	Presence of a control and/or comparison group was not applicable for this study.

5. Cases and controls were clearly defined and differentiated.

Well covered	The background/ demographic information for controls was clearly and comprehensively covered so that experimental groups were clearly distinguishable.
Adequately covered	The background/ demographic information for controls was covered so that experimental groups were distinguishable.
Poorly addressed	The background/ demographic information for controls was limited so that experimental groups were difficult to distinguish from one another.
Not addressed	The background/ demographic information for controls was not addressed.
Not reported	The background/ demographic information for controls was not reported.
Not applicable	The inclusion of background/ demographic information for controls was not applicable for this study.

6. The same exclusion criteria was used for cases and controls

Well covered	Study comprehensively details the exclusion criteria used for all participant groups (experimental and controls), clearly demonstrating continuity between groups.
Adequately covered	Study presents details about the exclusion criteria used for all participant groups.
Poorly addressed	Information relating to the exclusion criteria used is limited restricting confidence in determining whether the same criterion was used across all participant groups.
Not addressed	The use of exclusion criteria was not addressed.
Not reported	Exclusion criteria were not reported.
Not applicable	The use of exclusion criteria was not applicable for this study.

7. The authors used an appropriate method to answer their question e.g. validated attachment measurement (RQ, RSQ, ECR etc).

Well covered	The psychometric properties of the attachment measure are described and shown to have robust reliability and validity for this population.
Adequately covered	The measure has reasonable reliability and validity for this population.
Poorly addressed	Little information is provided concerning the reliability and validity of the attachment measure when used with this population.
Not addressed	The name of the measure is given but no further information is provided.
Not reported	The use of the attachment measure is not stated.
Not applicable	The use of an attachment measure is not applicable in this instance.

8. The statistics used were reported and appropriate E.g. Parametric vs. non-parametric.

Well covered	The analysis selected provides legitimate results. Sufficient information is provided including statistical analysis and descriptive statistics.
Adequately covered	Acceptable choices of analysis however information is limited.
Poorly addressed	The selected means of analysis is not sufficient to support the objectives of the study.
Not addressed	Quantitative analysis not addressed resulting in inconclusive findings.
Not reported	No details pertaining to the method of analysis reported.
Not applicable	Statistical analysis is not applicable for this study.

9. Were the main potential cofounders identified and taken into account in the design and analysis?

Well covered	Potential confounding factors were clearly identified and accounted for in the study design and subsequently included in the type of analysis selected so as to reduce the likelihood of biased or distorted conclusions.
Adequately covered	Potential confounding factors were identified and attempts were made to account for variables during the analysis reducing the likelihood of biased or distorted conclusions.
Poorly addressed	Potential confounding factors were not identified or incorporated in the analysis.
Not addressed	Study did not address the presence or likelihood of confounding factors.
Not reported	The presence of confounding factors was not reported.
Not applicable	Issues relating to confounding factors were not applicable for this study.

10. Were the results well reported e.g. effect size, significant vs non-significant results discussed?

Well covered	The results were comprehensively covered reporting effect sizes, confidence intervals and p-values where necessary. Power calculations were completed using acceptable effect sizes and clearly reported. Significant and non-significant results were clearly detailed.
Adequately covered	The results reported confidence intervals and p-values where necessary. Significant and non-significant results were detailed.
Poorly addressed	Confidence intervals, p-values and significant / non-significant results were not been sufficiently detailed.
Not addressed	Effect sizes, confidence intervals, p-values and power calculations were not addressed.
Not reported	Details of effect sizes, confidence intervals, p-values and power calculations were not included in the results.
Not applicable	Information about effect sizes, confidence intervals, p-values and power calculations were not applicable for this study.

11. Do the results fit with other available evidence?

Well covered	Results are comprehensively discussed in relation to studies in this field.
Adequately covered	Results are discussed in relation to studies in this field however comparisons are limited.
Poorly addressed	Results are not discussed in relation to studies in this field.
Not addressed	The study does not address the position of its results in terms of the wider literature in this area.
Not reported	Comparisons with available literature are not reported.
Not applicable	Comparisons with other studies are not applicable.

12. Have the limitations of the study been discussed?

Well covered	The limitations of the study were comprehensively discussed with proposals for future research provided.
Adequately covered	The limitations of the study were discussed with proposals for future research provided.
Poorly addressed	The limitations of the study were briefly mentioned with no proposals for future research provided.
Not addressed	No attempts were made to discuss study limitations.
Not reported	Limitations were not reported.
Not applicable	Discussion of study limitations was not applicable.

Appendix VI – Systematic review data extraction form

Data Extraction Form

Identifying information

Number:

Author(s):

Title:

Citation:

Country of origin:

Language:

Funding body:

Date of extraction:

Type of publication:

Article characteristics

Research question/aims and objectives of study:

Study design:

Inclusion criteria:

Exclusion criteria:

Recruitment procedure:

Setting:

Population

Number of participants who took part:

Number of participants included in analysis:

Number of excluded participants:

Control group:

Age range:

Gender:

Ethnicity:

Education:

Offence type:

Measures

Attachment measure:

Statistical analysis:

Findings

Mean and standard deviation:

Confidence intervals and p value

Quality of reporting

Clarity:

Comprehensiveness

Generalisability

Other noteworthy information

Appendix VII – Journal article interview guide

Interview Schedule

1. How did you choose to become a sex offender therapist?
2. How long have you worked as a sex offender therapist?
3. Describe your work as a sex offender therapist?
4. What effect has working as a sex offender therapist had on you?
5. What issues in working with sex offenders do you find the most difficult?
6. Has your work affected other aspects of your life?
7. Has your work altered the way you view yourself?
8. Has your work affected how you view the world and other people?
9. What do you find the most rewarding about your work?
10. How do you find delivering treatment to sex offenders in a group as opposed to 1-1 treatment?
11. What do you find difficult about group treatment?
12. What are the most enjoyable aspects of group treatment?
13. What motivates you to continue working as a sex offender therapist?
14. How do you manage your personal reactions to sex offender issues?
15. How are you able to maintain a therapeutic alliance with sex offenders?
16. What have you learned about yourself in working with sex offenders?
17. Do you have any additional comments you would like to make?

The Impact of Delivering Group Treatment to High-Risk Sex Offenders on A
Therapist's Sense of Self

Participant Information Sheet

We invite you to take part in a research project, which is being carried out in part fulfillment of Doctorate in Clinical Psychology at the University of Edinburgh. We believe it to be of potential importance. However, before you decide whether or not you wish to take part, we need to be sure that you understand firstly why we are doing it, and secondly what it would involve if you agreed. We are therefore providing you with the following information. Read it carefully and be sure to ask any questions you have, and, if you want, discuss it with others. We will do our best to explain and to provide any further information you may ask for now or later. You do not have to make an immediate decision.

What is the study about?

This study is looking to see if working with individuals who have sexually offended affects how a therapist views himself or herself. Working with people who have been victims of harm can be challenging for therapists and some research is showing that working with people who have committed harmful acts may also be difficult for therapists. This study is therefore interested in looking at how delivering group treatment to people who have sexually offended may affect how therapists view themselves and their work.

What does the study involve?

If you agree to participate, you will be invited to attend an appointment with Niamh Rice, a doctorate student at the University of Edinburgh. This meeting will last approximately 60 minutes and will take the form of an informal interview. During this discussion questions will be asked about how you have experienced delivering group treatment programmes to sexual offenders.

Will my results be kept confidential?

The information collected about you in this study will be anonymised. This means that your results will be linked to a special code that is stored separately on a password protected computer file. Only the research team will know your identity. All information obtained in the study will be stored securely in the department of psychology at the University of Edinburgh for five years. After this time the data and files will be destroyed.

Do I have to take part?

No. Participation in this study is completely voluntary. If you decide you would like to take part and change your mind, withdrawing your participation will not affect your work in anyway.

Where does the study take place?

The study will take place in your place of work if that is suitable.

Do I have to decide now whether to participate?

No. You can think about it for a few days. Taking part in this study is completely voluntary, and you do not have to give a reason for not wishing to take part. Even if you do decide to take part, you are still free to withdraw at any time, without having to give any reason for your decision. If you decide that you would like to take part please complete the attached consent form and return to Niamh Rice in the self-addressed envelope. Once we have received your consent form Niamh will contact you to arrange a suitable time for the interview to take place and send out a short questionnaire (6 questions) to find out some general demographic information. If you have any further queries concerning this study, please do not hesitate to contact us on the numbers below.

Is there a chance I might be harmed?

There is very little chance that you will be harmed during this study however if you believe that you have been harmed in any way by taking part in this study, you have the right to pursue a complaint and any resulting compensation through the University of Edinburgh who are acting as the research sponsor. Details about this are available from the research team. In addition, should you feel distressed during or after the interview please speak with your clinical supervisor or visit your occupational health department for support. Alternatively a list of support agencies that provide information and support is attached.

The State Hospital Research Committee and the University of Edinburgh Research Ethics Committee, has the responsibility for scrutinising proposals for research on humans, have examined this proposal and have raised no objections from the point of view of medical ethics.

Thank you for reading this information sheet and considering taking part in this study. If you have any questions please contact Niamh Rice: University of Edinburgh, Doctorate in Clinical Psychology, School of Health in Social Science, Medical School, Teviot Place, Edinburgh EH8 9AG; Tel 0131 651 3972 or email Niamh.Rice@nhs.net.

Many Thanks

Niamh Rice is a Doctoral student supervised by Dr. Ethel Quayle at the University of Edinburgh (ethel.quayle@ed.ac.uk Tel: 0131 651 3972) and Dr Lynda Todd at The State Hospital (Lynda.todd@nhs.net Tel: 01555 840293).



The Impact of Delivering Group Treatment to High-Risk Sex Offenders on A Therapist's Sense of Self

Support Agency Information

- AMSOSA (Adult Male Survivors of Sexual Abuse)
Helpline: 0845 430 9371 (weekdays 10am - 4pm; Wed 7 - 9pm) email: via website web: www.amsosa.com.
- CIS'ters (Childhood Incest Survivors)
Helpline: 023 8033 8080 email: admin@cisters.org.uk Provides help and support for adult women who suffered incest as a child.
- HAVOCA (Help for Adult Victims of Child Abuse)
Email (support): friend@havoca.org web: www.havoca.org. Provides information to any adult who is suffering from past childhood abuse. Website includes survivors' forum.
- Lifecentre
Helpline: 0844 847 7879 email: via website web: www.lifecentre.uk.com.
Telephone counseling for survivors of sexual abuse and those supporting survivors.
- Mankind
Helpline 01273 510 447 email: admin@mankindcounselling.org.uk web: www.mankindcounselling.org.uk Provides one-to-one counselling, therapeutic groups and couple counseling to men (age 18+) who have experienced sexual abuse at any time in their lives.
- NAPAC (National Association for People Abused in Childhood)
Helpline: 0800 085 3330 email: via website web: www.napac.org.uk NAPAC is the only national freephone support line for men or women who are adult survivors of any kind of childhood abuse. The website also provides a comprehensive list of resources, including publications, a book list and legal advice.
- Rape Crisis
Helpline: 0808 802 9999 (12 -12.30 pm, 7 - 9.30 pm every day of the year) email: info@rapecrisis.org.uk web: www.rapecrisis.org.uk. Services are

available to women who have been sexually abused at any time in their lives.

- Rape and Sexual Abuse Support Centre
Helpline: 0808 802 9999. The helpline is open 12-2.30pm and 7-9.30pm every day of the year, providing support for female and male survivors, partners, family and friends
- Refuge helpline:
Helpline 0808 2000 247 (Freephone 24 hour National Domestic Violence Helpline run in partnership between Women's Aid and Refuge) email: info@refuge.org.uk web: refuge.org.uk
- Samaritans
Helpline: 08457 90 90 90 (24 hours) email: jo@samaritans.org web: www.samaritans.org. Samaritans provides a confidential 24-hour telephone helpline, and you can also drop in at most Samaritan centres during the day or evening.
- Survivors
Helpline: 0845 122 1201 email: info@survivorsuk.org web: www.survivorsuk.org. Provides support for men who have been raped or sexually abused.
- Victim Support Victim Support line:
Helpline 0845 30 30 900 (Mon-Fri 9am-9pm, Sat and Sun 9am-7pm, bank holidays 9am-5pm) email: supportline@victimsupport.org.uk web: www.victimsupport.org. Victim Support is a charity that provides support and information to people affected by crime, including rape and sexual abuse, as a victim or a witness. The website provides details of local support branches.
- Women's Aid
Helpline: 0808 2000 247 (Freephone 24 hour National Domestic Violence Helpline run in partnership between Women's Aid and Refuge) email: helpline@womensaid.org.uk

Appendix IX – Journal article answer form



The Impact of Delivering Group Treatment to High Risk Sex Offenders on a Therapist's Sense of Self.

Answer sheet

☐

YES - I agree to being contacted to arrange a time to participate in this study. I am aware that I can withdraw at any time.

YOUR NAME:

(IN BLOCK CAPITALS PLEASE)

YOUR SIGNATURE:

TELEPHONE NUMBER:

You can return this Answer Sheet in the stamped return envelope.

Appendix X – Journal article participant consent form



Center Number:

Study Number: 1

Participant Identification Number:

Participant Consent Form

Title of project: The Impact of Delivering Group Treatment to High Risk Sex Offenders on a
Therapist's Sense of Self.

Name of Researcher: Niamh Rice

Please Initial Box

1. I confirm that I have read and understood the information sheet for the
above study. I have had the opportunity to consider the information, ask questions and
have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time
without giving any reason, without any medical care or legal rights being affected.

☐

3. I agree to take part in the above study

☐

Name of Participant

Date

Signature

Please type your name if you do not have an electronic signature and return this form to
Niamh.rice@nhs.net

Appendix XI – Journal article demographic information form



**The Impact of Delivering Group Treatment to High-Risk Sex Offenders on A
Therapist’s Sense of Self**

Demographic Information

Age:

20 – 24	<input type="checkbox"/>	25 – 29	<input type="checkbox"/>	30 – 34	<input type="checkbox"/>
35 – 39	<input type="checkbox"/>	40 – 44	<input type="checkbox"/>	45 - 49	<input type="checkbox"/>
50 – 54	<input type="checkbox"/>	55 - 59	<input type="checkbox"/>	60 - 64	<input type="checkbox"/>

Qualifications/Experience:

Professional Designation:

--

Number of years working with sex offenders:

--

Number of years delivering group treatment programmes:

--

Percentage of caseload involving trauma based work:

--

Appendix XII – Journal article research ethics committee approval letter



School of Health in Social Science
Medical School, Teviot Place
Edinburgh
EH8 9AG

Telephone: 0131 650
Fax: 0131 650 3891

Email: submitting.ethics@ed.ac.uk

Niamh Rice
Flat 1/1
1 Partickhill Road
Glasgow
G11 5BL

Dear Niamh

Re: The impact of delivering group treatment to high risk sex offenders on a therapist's sense of self

Application for Level 1 Approval

Thank you for submitting the above research project for review by the Section of Clinical Psychology Ethics Research Panel. I can confirm that the submission has been reviewed and was approved on the 24th September 2012. Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

With best wishes,

Yours sincerely,


PP Dr. Suzanne O'Rourke 

Appendix XIII – Journal article research ethics committee approval letter



Dr Niamh Rice
Psychology Department
The State Hospital

Date	31 October 2012
Our Ref	FD/aa
Your Ref	
Enquiries to	Ann Abernethy
Ext No	2221

Dear Dr Rice

Re: Research Proposal: The Impact of Delivering Group Treatments to High-Risk Sex Offenders on a Therapist's Sense of Self

Having considered the views of the Research Committee and noted that the study is exempt from the need for full NHS ethical approval under the amended GafREC guidelines, I write to give you Managerial Approval to proceed with your project. This is subject to you fulfilling the requirements of the State Hospital Research Committee.

May I take this opportunity to wish you every success in your endeavour.

Yours sincerely

A handwritten signature in purple ink, appearing to be 'F. Douds', written in a cursive style.

Dr Fergus Douds
Joint Associate Medical Director

cc. Jamie Pitcairn, Research and Development Manager.
Professor Lindsay Thomson, Medical Director.

Appendix XIV – Journal article debrief form



The Impact of Delivering Group Treatment to High-Risk Sex Offenders on A Therapist's Sense of Self

The purpose of this study was to explore whether delivering group treatment programmes to sexual offenders affects how a therapist views themselves and their work.

Despite extensive research investigating the effects of traumatic exposure on therapists who work with victims of sexual abuse, the literature exploring the impact of those working in the forensic field with individuals who have committed sexually abusive acts towards others is less well established (Clark & Roger, 2007). Research on therapists' reactions to working with adult sexual offenders 1-1 suggests that this work can often arouse intense and powerful reactions in therapists and can impact upon their identity and the way they view the outside world. The literature is less clear about how working with sexual offenders may affect a therapist's view of themselves however and is further limited regarding the potential impact of delivering treatment in a group setting. It is hoped that by exploring this question through informal interviews our understanding of how working with this client group is actually experienced by therapists will be improved.

This study was interested in both the positive and negative personal transformations therapists may encounter through their work. Looking at both the gains and costs of this work will afford a multifaceted understanding of the ways in which the therapeutic relationship and a therapist's sense of self may be impacted by working with sexual offenders in a group setting. It is hoped that by improving our understanding of the possible impact of this type of work we may assist in developing a strategy for maximizing the positive impacts and minimizing the negative impacts of working with this population.

If you are concerned about your feelings or mood state please contact your occupational health department. Your participation in this study was very much appreciated and should

you like to be informed of the outcome or have any questions about your involvement you can contact me through the Psychology department at: The University of Edinburgh, Doctorate in Clinical Psychology, School of Health in Social Science, Medical School, Teviot Place, Edinburgh, EH8 9AG (Tel: 0131 651 3972) or by email at, Niamh.Rice@nhs.net.

Thanks again.